Library

BULLETIN

OF

THE NEW YORK ACADEMY OF MEDICINE

INSTITUTED 1847

SECOND SERIES, VOL. III, No. 12

DECEMBER, 1927

PUBLISHED MONTHLY BY
THE NEW YORK ACADEMY OF MEDICINE
LANCASTER, PA. Lime & Green Sts.
NEW YORK Fifth Ave. & 103 St.

1927

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Entered as second-class matter, April 6, 1925, at the postoffice at Lancaster, Pa., under the Act of August 24, 1912.

Subscription $2.00 per year. Single copies, 25 cents.

THE NEW YORK
ACADEMY OF MEDICINE

VOL. III DECEMBER, 1927 No. 12

INCIDENTS IN THE RECENT HISTORY OF THE NEW YORK ACADEMY OF MEDICINE

DAVID BRYSON DELAVAN

The completion and occupancy of the beautiful building of The New York Academy of Medicine and the organization of its activities under the new conditions arising therefrom has entailed an amount of thought and labor which only those intimately concerned can realize. To their unwearying energy and devotion must be accorded full recognition and the highest praise. The success of their work, visibly manifest and everywhere acclaimed, will be for them an enduring monument.

But as Imperial Rome was the product of long endeavor, so the present triumph of the Academy is a realization of the visions and the patiently continued efforts of those by whom the work of reconstruction long ago conceived was originally inspired.

While many of the incidents of the movement have already been published, some have not. That these should be disregarded would mean a loss of historical data interesting in themselves and important for the completion of the story. No further explanation, therefore, is needed for the presentation of the material herewith presented.

The activities which led to the present development of the Academy pertain to three periods, each one although separate and distinct in itself, essential to the final result. The first includes the decade beginning about 1910 at which time it had become evident that the then existing accommodations would soon be outgrown, and continues through the trying times of the War, under the presidency of Dr. Walter B. James.

The second, the period following the annual address of Dr. George David Stewart in 1921, when the new order was inspired and suggestions for its realization were definitely set forth.

The third period dates from the entrance of the two great Foundations upon the scene to the consummation of the long-continued and devoted efforts of those chiefly concerned. The record of its history has already been published.*

The years immediately preceding and including the presidency of Dr. William M. Polk were important by reason of the rapid growth of the institution. The necessities attendant thereupon had already received serious thought and had aroused activities which, at that time particularly stimulated by Dr. Polk and variously exerted by others, culminated in the accession to the presidency of Dr. George David Stewart.

In 1909, an important movement was started to secure means for the enlargement of the Academy and, under the leadership of Dr. Reginald H. Sayre and other spirited members, was continued until the sum of $140,000 had been raised. This was known as the Academy Extension Fund.

The various attempts which followed these earlier efforts include the proposition of a new building at Seventh Avenue and 58th Street, abandoned for lack of sufficient means, and plans for alterations and additions to the existing building on 43rd Street.

In the years 1910–11 the properties 15 West 43rd Street and 10 West 44th Street adjacent to the Academy were purchased, and in October, 1910, a Committee on Plan and Scope, with Dr. Haven Emerson as Chairman, was appointed. In January, 1911, it is recorded that the work of this Committee and of the Committee on Finance was continued and that in March following, the Messrs. York and Sawyer, selected from a group of other prominent firms, were nominated and accepted as architects to prepare the preliminary plans for the proposed addition.

For a long while it had become increasingly apparent to the sponsors of the Academy that the unaided support of the medical profession could not be sufficient for its proper maintenance.

* *Vide* address delivered by Dr. Arthur B. Duel, Chairman of the Building Committee, at the Inaugural Exercises of the New Building. *Bulletin*, N. Y. Academy of Medicine, February, 1927.

Financial help from outside was imperative if the possibilities of the institution were to be realized. The sources of such assistance were not at that time evident, with one possible exception. For many years the Academy had virtually supplied the place of medical department to the New York Public Library. In view of this, and of the urgent needs of the Academy, it was decided to determine whether a reasonable share of financial support might not be expected from the Public Library. In 1910 an opportunity for testing the question arose through the death of Mr. John S. Kennedy, President of its Board of Trustees and its benefactor to the extent of a large bequest. In view of the dependence of the Public Library upon that of the Academy of Medicine, it seemed desirable to call the attention of the Trustees of the Public Library to the importance of the work being done by the Academy and to its need of funds. At the request of Dr. Polk the following letter addressed to him was prepared by the writer and was sent to a representative member of the Trustees of the Public Library, who at the same time had been the legal advisor of Mr. Kennedy:

"New York, July, 1910

"Dear Doctor Polk:

In view of the efforts now being made to secure funds from and through the medical profession for the expansion of the New York Academy of Medicine, I desire to call attention to the following facts:

"In addition to its already large foundation, the New York Public Library recently received by the will of the late John S. Kennedy, Esq., the sum of two million five hundred thousand dollars.

"The New York Public Library has no department of medicine. Dr. John S. Billings, Director of the Library, buys no medical books. On the other hand, he refers medical readers to the Library of The New York Academy of Medicine.

"The Library of the Academy of Medicine is freely open to the public, both medical and lay, irrespective of membership. As a matter of fact, it is extensively used by the lay public, including authors, journalists, lawyers, scientific readers, students of sanitation and of public hygiene, life insurance officers, architects, and investigators representing a wide variety of other non-

medical departments. Thus it covers a field of practical and indispensable usefulness to the public, not only through the profession of medicine, but in addition through an extensive range of outside interests. It is the only library of its kind in New York City. Of the great medical libraries of the world those of the Faculty of Medicine of Paris and of the Surgeon-General's Office of the United States alone surpass it, while the extensive and splendidly organized library of the Kings County Medical Society, in Brooklyn, is remote for New York City readers.

"The Library, however, forms but a part of the institution known as the Academy of Medicine of New York. This in fact has been so organized as to constitute one of the most powerful educational factors in the medical world. The general scope of its work may be learned in part from the published programs of its regular meetings.

"Well-established for many years, its success has proved the wisdom of its organizers and its example has been widely followed in other cities in this country and abroad. Within the last three years (1907) a similar institution has been started in London and has met with enthusiastic support.

"The Academy of Medicine is absolutely non-sectarian in every sense. It is not nor has it ever been allied to any other institution. It is open to the whole profession, is managed and patronized by the best men of the profession for the general good of all, is entirely independent of the influence of any circle or *clique*, and affords a general meeting place for every respectable physician irrespective of affiliation; an indispensable bulwark against charlatanry; the standard bearer of scientific progress and of public philanthropy.

"As an institution, it is worthy of the attention of any student of education. It is the fountain head of medical knowledge necessary to the welfare of every medical institution and of every individual. Its influence for good is incalculable. Already it has accomplished much. Properly equipped, it is capable of accomplishing vastly more.

"Its present financial standing is published in the annual report of the Treasurer. The funds for its establishment and maintenance have been collected with much difficulty through a long series of years, generally in small donations. Much has come

from the medical profession itself, very little from outside, although the institution exists in the broader sense for the distinct benefit of the public at large.

"From the terms of the Kennedy will it is evident that the bequest to the New York Public Library must of course go to that institution. The Library of the Academy is practically an integral part of the New York Public Library; at the same time it is, legally, an entirely independent institution. It therefore cannot claim a share in the Kennedy bequest or in any other similar to it. Its actual needs are great and are rapidly increasing. That they should not be met would be a public misfortune. Is it not possible when so much is being done for institutions of infinitely less value that the public at large should realize the importance to itself of this splendid guardian of its welfare and grant it the support necessary to its full and complete development?"

The answer to Dr. Delavan's communication confirmed the statement that the gift of Mr. Kennedy was left specifically for the Public Library, and therefore could not be used otherwise. The letter is as follows:

"New York, July 23, 1910

I read your note with regard to The New York Academy of Medicine with interest. I know generally of it. Its needs should be made more apparent evidently than they have been. If any opportunity occurs to me to serve its interest, I certainly will do so. Of course Mr. Kennedy's bequest must go entirely to the Public Library."

In the years which have elapsed since the above letter was received, nothing further has been heard on the subject.

During the period of the World War the conduct of the affairs of the Academy had been difficult. Large numbers, more than one-half, of its most active and efficient members were engaged in war services both abroad and at home; its resources were crippled, and the unusual obligations undertaken by it were engrossing. Notwithstanding a situation unprecedented in its history, with rare good fortune the leadership had fallen upon Dr. Walter B. James, whose clear judgment, commanding personality,

and untiring devotion brilliantly guided it through the two terms of his administration.

With the passage of time meanwhile the situation was becoming progressively acute. In 1917 the question of additions to the 43rd Street building was temporarily revived. Interrupted by reason of the war, it was again taken up in 1919 and working drawings were prepared for alterations and additions to the old building. These failed to be satisfactory, and no progress was made for nearly two years.

To Dr. George David Stewart, who succeeded Dr. James as President in 1919, is due the credit of having inaugurated the effort which, carried on by him with unfaltering energy and courage through six arduous years, finally resulted in the Academy of Medicine as we have it to-day. The history of this important period should especially engage our attention.

At a meeting of the Trustees held January 28, 1920, the question of the advisability of proceeding with the plans proposed for 15 West 43rd Street was discussed at length, and it was decided that owing to the high cost of construction and the difficulties and uncertainties attending all new building enterprises, it was unadvisable to proceed at that time, and the President was requested to draw up a statement giving the reasons for further delay in the building project, to be sent to each contributor to the Academy Extension Fund.

The Treasurer was instructed to pay from the Extension Fund the bill of the architects for work upon plans for the new building.

In his presidential address in 1921, Dr. Stewart eloquently called attention to the condition of the institution. He demonstrated that the activities of the Academy had far outgrown the capacity of the building, especially in the case of the Library department. The small dwelling house adjacent to the main building of the Academy, the remodeling of which had been under consideration, would require complete reconstruction, while the space thus added would be slight and certain to become insufficient within a short time. Moreover, both buildings were dangerously non-fireproof. At the following meeting of the Council, January 26, 1921, these matters were discussed, with special reference to the last named, and it was voted that the

President be authorized to appoint a Committee from among the members of the Academy for the purpose of securing funds for the erection of the extension to the Academy building on the property 15 West 43rd Street.

The suggestions made on that occasion seemed inadequate to the writer, by whom a letter was addressed to the President, setting forth the necessity for an endowment, and for a building which would not only answer present requirements, but would make provision for hitherto unconsidered functions and for the natural growth of all.

"January 27, 1921

"Dear Doctor Stewart:

Apropos of the discussion yesterday evening relative to the future development of the New York Academy of Medicine, I desire to submit to you a number of ideas which have engaged my earnest attention, the more so because the propositions offered at our recent meeting seem inadequate to the present and future needs and possibilities of what should be the most important institution of its kind in the country.

"*Endowment.*—Undoubtedly the most important necessity of any institution is the means necessary for its financial support. This, the Academy of Medicine has not had, either in its early history or at the present period of unusual financial stress. Primarily the function of the institution is educational. Few educational institutions are run within the limit of the means of direct beneficiaries. Seminaries, colleges, universities, and particularly medical schools, can seldom exist upon the fees collected from pupils. Adequate endowment is essential if the institution is to attain the highest usefulness of which it is capable. In our powerful and wealthy metropolis, museums, libraries, universities, schools, hospitals, and philanthropic institutions of many kinds depend upon outside support for their very existence. The sources of revenue within themselves would never suffice for their maintenance. Recent experience has proved that the Academy is no exception to this general rule. Under existing conditions it cannot be properly maintained, much less can it effect the expansion so urgently demanded.

"The time seems to have arrived when the policy of the institution must be carefully considered, the question being whether it

shall continue on in its present modest way or whether, the means being provided, it shall be enlarged and developed in a manner worthy of the dignity, the influence, and the usefulness of the representative medical institution of our great city.

"*Buildings.*—To fill the requirements of the situation, not only for the present but for the expansion which is sure to follow the growth of the Academy in the increasing number of its beneficiaries, the expansion of its present functions and the development of new fields of work, it is necessary that we should have space of such considerable extent as to make possible additions sufficient to meet increasing needs.

"Temporary expedients can only satisfy indifferently, and for a comparatively short period of time. Other institutions around us are growing with rapid strides. It is for us to remember that The New York Academy of Medicine is the representative medical institution of our country, as well as of our city, a city great in its scientific attainments, great in its resources, and supremely great in its generosity. The home of the Academy should be equal to the splendid possibilities of usefulness which it has already attained, as well as to those which lie before it; worthy of the high degree of dignity which it represents. The more general appreciation of its position and realization of its importance to the public welfare should surely win for it full and enduring support."

Several recommendations relating to the details of the subject were set forth in the letter and these, elaborated and added to by others, were soon afterwards presented to large groups of Academy members.

The immediate result of this communication may be learned from the record of the minutes of the Trustees. "At a meeting of the Trustees held February 23rd, 1921, the President reported that he was still engaged in the matter of appointing a committee on the new building and wanted further advice from the Trustees in reference to this matter, particularly in view of the receipt by him of two letters, one from Dr. James, the other from Dr. Delavan."

The letter of the latter represented an aspect of Academy expansion which appealed to the President and which he wished to communicate to the Trustees.

After the reading of these letters and much discussion thereon, it was voted, in view of the facts elicited and those of Dr. Delavan's letter, that the whole matter be referred to the Council for the purpose of getting its opinion, with the request that the Council make the question of a new building the chief topic of its consideration at its coming meeting on the evening of the same day, February 23rd.

At the above mentioned meeting of the Council the President stated that he had received a letter concerning endowment and expansion of the Academy which he had communicated to the Trustees. As the President had been requested by the Council to appoint a Committee to deal with this question, the Trustees desired the views of the Council with reference to the type of expansion which the Academy should consider and requested that the Council make this its chief topic of consideration at this meeting. The letter referred to above was then read for the information of the Council and each member present was asked to state his views thereon. After full discussion, it was resolved that the President at his discretion call a meeting of a group of members of the Academy, including the Council and Trustees, for the purpose of discussing this question.

In accordance with this recommendation of the Council, a dinner was given by the President of the Academy at the Lotus Club on the evening of March 21, 1921, at which were present about thirty representative members of the Academy to whom the propositions of Dr. Delavan were presented. Several upon hearing them were unconvinced, believing them to be "impractical," "hopelessly expensive," "a dream." To the objection that the proposition entailed expense far in excess of that hitherto required, it was answered that other institutions of the city of even less importance than the Academy were generously supported in the requirements of far larger outlay; that the Academy was the most important medical institution in the country's greatest metropolis, and that its wide and multiplex usefulness rendered it worthy of support commensurate with its value to the community and its indispensability to the problems of medicine, as well as with the dignity of the profession and the wealth and influence of the city of New York. Now, radical changes were needed. The endowment and expansion suggested might

well require a considerable sum, of which five million dollars was not an undue estimate, conservative when compared with the cost of other correspondingly great institutions. The time had come when the public, for whose benefit the Academy exists, should be enlightened as to its needs and confidently expected to respond to them.

A large majority were favorably impressed by the facts and arguments urged. A few weeks later, on April 26th, a second dinner was given by the President at the Lotus Club to another important group to whom the same presentation was made as that explained above. Several were present who had attended the previous dinner and who at first not favoring the plan had subsequently recognized its value.

The following letter to the President, earnestly expressive of the sentiments of its author toward the Academy, affords a fine revelation of the spirit of the man.

"April 26, 1921

"Dear George:

"I cannot tell you how sorry I am that I am unable to be present at your dinner tonight, for I am sure the future of the Academy will be discussed and I am sure, too, that you know how close the Academy and its welfare lie to my own heart.

"In relation to the question of Academy extension, may I say that I believe that before going on with the proposed building at 15 West 43rd Street another effort should be made to secure funds for putting up a new Academy on perhaps some other site and one which would be worthy of the dignity, and importance, and value of the institution, and which would better house its various activities.

"You will remember that three or four years ago we failed to secure the aid of one of the great Foundations. Since that time I believe these agencies have come to work more together and are more ready to cooperate to bring about worthy educational ends. Might it not be possible to show say, three of these, that the Academy is the seat and home of the higher medical education of Greater New York with its more than five million people, and that aid given to the Academy is aid given to one of the most important links in the educational system of the country? Should a short vigorous campaign now—say of two or three

weeks—fail to arouse an interest in our larger project, then I believe we ought to go on with the smaller one, trusting that the passing of twenty or twenty-five years will manifest here in New York a public endowed with greater vision or a profession with more power of presentation and persuasion.

"I believe that I have several arguments that have not yet been presented to these Foundations and that I think would have some force.

Sincerely yours,

WALTER B. JAMES"

At the Trustees' meeting, held March 23, 1921, "the President reported on the subject of a building committee which had been left to him two months before. He deemed it wise that this committee should organize and begin work at once, so as to report to the Trustees at their next regular meeting. Two committees were appointed, one on Plan and Scope; the other on Building and Finance," and the following letter was addressed by the President of the Academy to the writer:

"March 24, 1921

"At a meeting of the Trustees yesterday a Committee on Plan, Scope and Propaganda was formed, the functions of which Committee are to state plans for the future development of the Academy, and then to devise means of bringing this before the public and before the great foundations in the hope of raising money to carry out those plans.

"The Committee so far constituted consists of yourself as chairman, and Drs. Lewis F. Frissell, L. Emmett Holt, N. E. Brill, Walter B. James, S. S. Goldwater, Arthur B. Duel, Rufus Cole, Warren S. Stone, Frederic E. Sondern, Frederick T. Van Beuren, and Warren Coleman. Your committee has power to add to its own numbers.

"It is hoped that you will be able to formulate plans for the future development of the Academy and be ready to present them prior to the next meeting of the Trustees, which takes place on the fourth Wednesday of April.

"A second Committee was appointed whose function it is to consider carrying out our present plans and raising the money therefor. Should your Committee be able to report favorably

within a reasonable time, it would materially modify the action of the second committee. On the other hand, if your Committee reports unfavorably, then I think the second committee should become active. In other words, their action will depend something on yours. You will no doubt hear of this formally from the Secretary of the Board of Trustees, but because of your great interest in the matter I am writing to you personally."

The Committee on Building and Finance, appointed at the same time as the Committee on Plan and Scope, was as follows: Dr. L. Emmett Holt, chairman, Dr. Charles L. Dana, Dr. W. Gilman Thompson, Dr. Seth M. Milliken, Dr. Edward D. Fisher, Dr. Walter B. James, Dr. James B. Clemens, Dr. Alfred Meyer, Dr. Charles H. Peck, Dr. Royal S. Haynes.

At the meeting of the Council held April 27, 1921, the question of Academy expansion as hitherto proposed was further discussed. The consensus of opinion was that before taking any steps to carry out the plan under consideration, another effort should be made to institute the larger plan, namely, to buy a larger plot of ground elsewhere and erect a new building, and it was voted that the President be given full power to carry out the plans for the expansion of the Academy along the ideals outlined in the discussions.

Several meetings of the Committee on Plan and Scope were held before the summer vacation. In order to facilitate matters, the Chairman prepared a prospectus in which was set forth his own views as to the requirements and the possibilities of the Academy. A copy of this prospectus was sent to each member of the Committee for consideration during the summer. In the early autumn other meetings of the Committee were held, with the result that the propositions of the Chairman's prospectus were approved. Several of them have since been adopted. The rest we hope may be, in due course of time.

The original prospectus is as follows:

New York, June, 1921

To the President and Council of the

New York Academy of Medicine:

A series of suggestions relating to the proposed reorganization of the New York Academy of Medicine has been elaborated by

the Chairman of the Committee on Plan and Scope, and a copy presented to each member of the said committee as follows:

The accompanying outline is intended to present categorically the matters under advisement by our Committee on Plan and Scope of the Academy of Medicine. Many of the items are already familiar to you. Will you not study the various points, note upon the slips accompanying the memoranda any suggestions occurring to you, send these notes to me at your early convenience, and be prepared to attend a meeting of our Committee early in the fall.

Please consider especially questions relating: First, to the number, character, and capacity of the audience halls and rooms necessary to the uses of the Academy; secondly, to the scope of the activities of the Academy.

HALLS AND ROOMS

Rooms for Executive Officers

(1) A special room, properly equipped, for the President of the Academy; his assistant; his stenographer.

(2) Suitable rooms and offices for the Librarian, and other officers, and their staffs; said rooms properly located and arranged for the convenient carrying on of the executive work.

Reading Rooms

General Reading Rooms:

For fellows of the Academy, for non-members, medical, and lay, and for medical students.

Private Rooms:

(*a*) For the use of special investigators and their assistants. Should be of sufficient size to contain a desk, table, and stenographer's table, and a small locker for the safe-keeping of books and material in the absence of the user.

(*b*) For special readers—a series of small rooms or alcoves for the use of readers requiring quietude and isolation—furnished with a small writing-table.

Reception Rooms, Council Rooms, Committee Rooms.

Audience Halls

Main Audience Hall—its size and its location in building.

Rooms and Audience Halls for Sections

Rooms for Sections should in most cases be individual, each section having its own, furnished and equipped in accordance with its special needs and sentiments, and offering facilities for the permanent display of objects of historical and scientific interest pertaining to its department.

Since the stated meetings of Sections are held at definite intervals, and since a hall of considerable capacity is needed to accommodate the audiences attending such meetings,

(*a*) Audience halls of ample size should be provided.
(*b*) The use of these halls, in certain instances to be shared by several sections through proper adjustment of dates of Section meetings.
(*c*) Adjacent to some of them should be rooms for the proper reception and examination of patients illustrative of subjects under discussion.

Halls for Medical Meetings (Temporary)

Halls and meeting rooms available to outside medical societies, etc., of proper standing, should be provided, these being sufficiently desirable to attract medical and allied scientific associations of the higher order.

Rooms for Medical Organizations (Permanent)

To outside well-accredited medical organizations, certain floors of the building to be devoted to the housing of such organizations until needed for the Academy's own use.

Display Rooms

For rare books relating to the history of medicine, portraits, pictures and illustrations of scientific or historic value, and charts, and for the proper storing and care of such collections.

Exhibition Rooms

Suitable halls for public exhibitions—medical, surgical, sanitary, hygienic, food, etc.

FUNCTIONS

In addition to the activities already in operation, to which should be given every possible encouragement and support, several others should be established. There should be a Literary Bureau; a Stenographic Bureau; a Bureau of Publication; a Summer Register; a Safe Deposit Department; a Museum; a Bureau of Information relating to general medical activities; a Restaurant; a Committee of Reception and Social Entertainment; and the hours for readers should be lengthened.

The plan, as suggested by the chairman, would include the following items:

LIBRARY

The first and most important function of the Academy is that of a medical library. That of the Academy of Medicine represents one of the largest and most available collections of medical literature in the world. Wherever the value of books is most appreciated, there is furnished for them a worthy repository. The libraries of great cities and universities are among the most imposing of their public monuments. Designed for utility rather than for display, the building of The New York Academy of Medicine should be worthy of the dignity of the institution; adequate to its present and prospective needs; perfectly designed and constructed; equipped with thoroughness of detail and perfection of device; a model to the world for the future as it has been in the past.

MUSEUM

The interest shown in museums in general is attested by the character of those interested in their development and management, by the vast sums devoted to their support and by the ever increasing patronage of the public. The medical museums of Europe have been famous through many generations. The museum of the United States Army in Washington is a treasure-house of information. Aside from it there are few in this country worthy of the name and none in New York. In this great metropolis no single institution could assemble and maintain such a museum as might be created by the Academy of Medi-

cine, which represents all. It would be invaluable as a means of information and instruction to a wide circle of inquirers, as is the Library. Thus it would serve most usefully the welfare of the public throughout the world.

The main interest of the museum should be historical. Already the Academy is rich not alone in its library. From the beginning it became the repository of objects in large number and variety pertaining to the history of medicine, both in general and as relating to New York. These things, consisting of portraits of distinguished members of the profession, pictures, engravings, documents, surgical instruments, original models of instruments, etc., have increased in volume and in value until they have become an important feature of the institution, next to the library its most interesting and valuable possession. They form indeed a highly instructive museum of medical history, acquired during half a century through the efforts and liberality of men of discriminating foresight. This feature of the Academy must on no account be slighted, still less given over to neglect. Aside from the intrinsic worth of our collections their importance for the instruction and inspiration of ourselves and of generations to come is inestimable. From every point of view, whether of practicality or of sentiment, they are priceless, irreplaceable treasures.

Moreover there should be departments Anatomical, Physiological, Pathological, Histological, Bacteriological, Botanical, Educational.

In addition to the objects already mentioned, the historical department should contain a wide variety of articles pertaining to the history of medicine, with special reference to those associated with its history in the United States, presenting representative models of original instruments and appliances; also, exhibits showing the development of instruments; medical and surgical devices, and methods as found among ancient and primitive peoples; and coins and medals relating to medicine.

Typical collections of paraphernalia useful in the illustration of medical lectures, the different groups to serve as models for the enlightenment of medical instructors in general, so that an instructor in any medical school could gain definite and reliable

information as to the best illustrative apparatus for his department.

Under proper expansion of this department the publication of series of illustrative charts, etc., for lecturers could be undertaken.

A museum originated in the Academy of Medicine could be developed until too extensive to be contained therein, in which event it could be used as the nucleus of a great independent organization, having its own building, thus releasing the space occupied by it to the academy's growing needs.

Stenographic Department

There should be a department under a competent head for the supplying of trained medical stenographers, reporters, typists, illustrators and photographers, through the medium of which the most reliable and skillful service could be promptly obtained.

Literary

Heretofore at the Academy, the services of reliable medical bibliographers and translators have been difficult to obtain. Also, without supervision and with no responsibility to any definite head, they have often been tardy in the execution of work and without restraint in charging for it. This department would be definitely organized, with a responsible director who should supply efficient operatives and have general supervision of the work, to the end that the latter be executed and delivered in good form and without undue delay and that the charges should be correct.*

Publication

The Academy should maintain a bureau of publication, for the editing and publishing of its transactions, reports and such other matters as may pertain to its activities. Through this bureau, printing and publishing facilities should be made available to other medical bodies and to individuals, and encouragement, including financial support, given to the bringing out of medical

* Since the above was first presented the idea has been carried out in the admirably organized "Department of Literary Research" of the American College of Surgeons.

works of unusual merit or scientific importance. Such a department is well illustrated in the organization and conduct of the Yale University Press, an institution properly endowed and entirely independent as to management and to financial support but under the control of the University. Its value has long since been demonstrated in the high character of the books it has sponsored, the beauty of its press work and the acknowledged dignity of its position in the world of literature. A department in the Academy of Medicine based on somewhat similar principles should become as important in the field of medicine as have its prototypes in the greatest of the universities of England and the United States. It is earnestly recommended that steps be taken by the Academy to be the first to initiate the organization of such a department and to zealously further its progress, not only for the advancement of medical knowledge, but also as a valuable example to other great medical institutions.

Safe Deposit Department

The Academy should provide a department for the safe-keeping of its own valuables and those of others who might be accorded its use. This department should be equipped after the manner of the usual fire-proof safe deposit vault. In it could be kept the archives of the Academy; rare manuscripts and other treasures calling for special protection; secretary's reports of the various sections of the Academy; secretary's reports of accredited medical societies; and memorabilia of private ownership, of possible future interest to the Academy.

From the placing of society archives and transactions in the hands of officers filling more or less temporary appointments it has frequently resulted that the papers have been scattered, mislaid or even entirely lost, sometimes from carelessness, more than once through the death of the one holding them. The members of the society have had no knowledge of their whereabouts, nor the family of the deceased of their importance. It should be understood that such material when not in use would always be found in its safe deposit compartment. Thus, in case of accident to the secretary, the officers of the society could at once recover their papers intact. The plan relieves the secretary of the burden of transporting the records to and from his residence as well

as of the responsibility of their keeping, while it insures their absolute preservation in a definite place.

Mechanical difficulties in respect to the storage of books and papers, such as the effects of changes of temperature, dampness, etc., doubtless could be overcome. The expenses of the management would be defrayed by the rentals of the boxes.

Medical Education

Much could be done by such an institution as the Academy in the way of supplementing medical courses, especially for graduates in medicine. Topics could be treated which might not be in line with regular systematic courses, distinguished men presenting them. These lectures, free to all, might be made attractive and highly instructive to a great variety of medical men, although they should not be allowed to conflict with the basic object of the Academy, namely, the Library.

Provision for Medical Students

New York City has become a great center of medical education, both under-graduate and graduate. Medical books are expensive; the average medical student is not wealthy, while board and fees are costly.

The Academy would increase its usefulness by furnishing a reading room or rooms for students, and supplying the necessary books in return for a nominal fee. This would relieve the student from a heavy burden of expense and—a matter of supreme importance—demonstrate to him the meaning and the value of a fine library, and fix upon him "the reading habit" early in his career.

A Center of Medical Activities

There should be a Bureau of Information based upon the principle of the "Bulletin of Weekly Clinics," but giving in addition definite information as to all medical activities of the city in general. With the growth of medical education this department would become progressively more useful and should receive substantial encouragement.

In other buildings, near the Academy, dealers should be encouraged to locate who would furnish all medical necessities and

conveniences as, for example, book-sellers, instrument-makers, surgical and sanitary appliances, a thoroughly equipped pharmacal establishment, and every other legitimate thing pertaining to the life and work of the physician.

Social

Special provision should be made for the reception and entertainment of distinguished visitors and guests, and proper funds and facilities furnished for this and for the purposes in general of the furtherance of friendly relations with deserving representatives of our own country and from abroad.

Distribution of Books

1. In the future, branches might be established, as with the New York Public Library.

2. Distributing stations in outlying districts, at which books from headquarters can regularly be delivered by carrier to be called for by those having ordered them, and by them returned to the station when used and thence restored to case. Such stations might supply journal rooms of limited scope.

Philanthropic Activities

The Public Health Committee of the Academy, which contributes its important share to the welfare of the country, is but one of the institution's philanthropic activities. Others of more or less allied character, such as the Child's Welfare Committee, are in active operation, while the future is certain to develop more.

Summer Register

With the coming of vacation time many consultants leave the city, some for the season, others for a few weeks at a time. Heretofore it has been difficult to learn who are in town and who are away. To all, and especially to those at a distance desiring prompt aid, the task of securing it has often been attended with difficulty, expense and serious delay. Office after office has been called by long distance telephone or telegraph without success; or some overworked friend in town importuned to perform the same service. There are few occasions during the summer when excellent consultants cannot be obtained, if only their presence in town were known.

A simple solution to this difficulty would be to establish at the Academy a bureau at which those who for any length of time expect to be in town and subject to call could register their names and the dates between which they could be found. By communicating directly with the bureau the applicant could at once learn of all available in any given specialty, make his own selection and through the bureau be placed in direct communication for the purpose of final arrangement. Such a bureau or department could be conducted with little expense or trouble, to the great convenience of all directly concerned, both applicants and physicians.

Restaurant and Entertainments

Provision should be made for special entertainments by outside caterers. For this purpose proper space and equipment should be provided.

There should be a buffet, offering simple but adequate service for the personnel and for accredited visitors to the Academy, at least for supplying meals during the midday hour, at a minimum charge, as is done in the National Library of Paris, and elsewhere.

It is imperative that *additional space and improved facilities be provided, not only for the growing needs of the functions already established, but that the future welfare of other interests not now in existence be foreseen and provided for.*

BUILDING

The building of the Academy

(1) Should be most centrally located.
(2) Fireproof, of the first order of modern construction.
(3) Foundations and substructure strong enough to sustain heavy additional superstructure, for space to meet requirements of future growth.
(4) Perfectly ventilated and lighted, the latter where possible by the indirect method.
(5) There should be provision for the parking of cars.

With relation to the outside world, the work of the Academy has been carried on with such dignified modesty that its useful-

ness to the general public is all too little understood. Many institutions of less merit and of far less public importance have been generously endowed. Unless we are to fall behind, the time has come when this matter of endowment and expansion should be seriously considered and discussed. Independence of action is necessary. Suggestions may be gained from various sources, but in the main we shall have to use our own initiative and evolve our own plans.

The TIME *for building is not as important as is the formulation of a general plan, comprehensive, far-reaching, and adequate. We can well afford to postpone definite action for a short period in view of the importance of a wise decision.*

The reception by the members of the Committee on Plan and Scope of the list of recommendations as above set forth, made by the Chairman, was favorable. Few additional suggestions were offered. Of these the most notable was presented by Dr. Warren Coleman, who urged the importance to the Academy of an official publication or Bulletin, in which should be set forth the current activities of the institution.

The following letter to the Chairman is worthy of record:

"July 27, 1921

"I have yours of the 22d, together with your interesting compendium of questions. I have already gone over them and will further consider them and try to be of any service in the autumn. It is a most helpful and suggestive list and will be very useful.

WALTER B. JAMES"

With the resumption of activities in the autumn, affairs were seriously discussed and at a meeting of the Council held November 3, 1921, it was the consensus of opinion that there should be a definite plan developed for the proposed building, that this plan must be worked out with deliberation and care, and that it should be determined upon at a comparatively early date. As to the question of a museum, it was agreed that there should be a museum, limited in its scope to objects of historic or unusual scientific interest, these not to include so-called wet pathological specimens.

The progress of events is sketched in the following brief summary taken from the Records of the Academy:

On October 25, 1922, the President was given authority by the Council to appoint a Committee on Functions of the Academy, with sub-committees on Education, etc., and the following were appointed: Dr. Samuel A. Brown, Chairman, and Drs. Walter L. Niles, William Darrach, Rufus I. Cole, Geo. Gray Ward, James Alexander Miller, Charles L. Dana, D. Bryson Delavan and Karl M. Vogel; also a Committee on Site and Construction, and a Committee on Progress, to function in cooperation with the President.

January 24, 1923, the President announced the appointment of a Committee on Site and Construction, as authorized at the October meeting, as follows: Hon. Frank L. Polk, Chairman, and Drs. Walter B. James, William Gilman Thompson, Arthur B. Duel and Bernard Sachs.

March 28, 1923, the names of the Building Committee were announced, as authorized at the previous meeting by the Council, and were ordered on record as follows: Dr. Arthur B. Duel, Chairman, and Drs. Goldwater, Burlingame, Holt, Niles, van Beuren, Wright, Keyes, Delavan, James, Tilney, Haynes, Milliken, Thompson, Dana, Sondern, Farr, Riley, Clark, Dougherty, Anderton, Humphries, Bechet, St. Lawrence, Alger, Rathbun, Caldwell, Forbes, Clemens, and the President, ex-officio.

During the early part of 1923 an active campaign was carried on for securing funds for a new site and increased endowment. A committee consisting of sixty members of the Academy was created by the President and placed under the able chairmanship of Dr. Royal S. Haynes. This committee carried out its work with great enthusiasm and through its efforts over $200,000 was subscribed by 1,313 Fellows of the Academy, to which was added about $325,000 from gifts of various of their friends, aggregating over $500,000. This amount, with the equity of the 43rd Street property, was sufficient for the purchase of a lot at the corner of 60th Street and Park Avenue, for which $754,000 was paid. After much careful study it was found that this site presented several objections, so serious that in 1924 it was determined to relinquish it, and the plot was advantageously sold for $1,000,000, immediately following which the present site was determined upon and purchased for the sum of $225,000, together with an adjacent lot on 103rd Street for $17,500.

The question of location had been attended with many difficulties. The character of 43rd Street had completely changed. The street had become crowded and noisy, access to it was difficult and parking was impracticable. Entire reconstruction of the buildings would require several years, necessitating meanwhile the temporary transference and disuse of the library. It became evident that a new location must be sought. After long-continued and diligent search the 60th Street plot had seemed suitable. In elaborating the architectural plans, however, it was demonstrated that the space was inadequate to the inevitable expansion of the stack room. A sale of this property, fortunately highly advantageous, was therefore effected, and the new location secured. To any who may have been disappointed, it will be some compensation to know that the 60th Street corner is one of the noisiest in the city, having the subway and the crowded traffic from the Queensboro Bridge on the north, the New York Central and the New Haven railroads, together with the traffic of Park Avenue on the east, and the disturbances of the trolley lines and the traffic of the 59th Street thoroughfare and of Madison Avenue on the south and west. Moreover, the geology of this block front is peculiar. The lake at the southern extremity of Central Park finds its outlet to the East River underground. When the adjacent half of the block extending to 59th Street was recently excavated in the process of the erection of a heavy building, these subterranean streams presented unexpected difficulties which cost the loss of many months of valuable time and the expenditure of a large amount of capital before being overcome, in fact resulting in the bankruptcy of no less than two contracting firms. While the conditions at the 60th Street corner were not quite as serious, the expense of securing stable foundations was excessive.

The final choice of the present site of the Academy was based upon wise prevision which is already recognized and which time will abundantly confirm.

In the meantime, while these efforts toward endowment and location were being carried on, the portentous question of funds for the new building, so long a problem, was still in abeyance. The president, with other zealous associates, although working with indefatigable effort to secure the aid of various friends of

large private means, had not succeeded in so doing excepting in the case of several whose very liberal contributions were nevertheless insufficient to meet the necessary amount. It having been demonstrated that further effort in the direction of private support would be likely to incur discouraging delay it was determined to appeal to the leading foundations. A letter was prepared by Dr. Stewart and placed before them.

"January 23, 1922.

"To the Trustees of
The Rockefeller Foundation
The General Education Board
The Carnegie Corporation

"Gentlemen:

"The New York Academy of Medicine, founded some seventy-years ago, now occupies a building which it owns on Forty-third Street, just west of the Century Club. In this building, which is five stories high, is housed its library of approximately 130,000 volumes, and in it are conducted all of its activities.

"It is the purpose of this memorandum to bring to your attention, not so much the present work and the immediate activities of the Academy of Medicine, but rather to make clear that the position which it now holds—creditable as it is, and the work which it is now doing, valuable as it is—represents but a small part of what it can accomplish if it can be housed in such a building and provided with such resources as to enable it to render to the profession and to the community the service of which it would be capable. We beg, therefore, to lay before you in the first place a brief statement of the place which The New York Academy of Medicine aspires to fill.

"It is perhaps not too much to say that the progress of the medical profession will in the main be effected through the men of the profession and in a large measure through the organizations which they set up for this purpose. It has been the weakness of many medical associations that they represent a local and often too exclusively a practitioner's view. Local medical societies, fruitful as they have been in stimulating the interest of the medical profession and in discussing questions of public health,

have nevertheless remained to a certain extent partisan, representing in many cases a single group of physicians and surgeons, and dealing with medicine mainly from their point of view.

"In comparison with this situation, an Academy of Medicine, organized as that of New York, embraces all groups of medical practitioners. It represents no particular professional interest. It unites, as does no other agency, the best thinking and the highest aspirations of the medical body.

"The work of the Academy naturally centers about its great library. Except the Medical Library of the Army Medical Museum in Washington, no other collection of medical literature in this country approaches the library of the New York Academy of Medicine. It contains not only the most complete collection of books relating to the history and to the practice of medicine, but likewise the best collection of medical journals and pamphlets. This library is made as accessible to the profession, not only of the City but of the country, as the crowded conditions of the present building will allow. Unfortunately, the building is not fire-proof and the medical library which it houses and which could never be replaced, may at any time be destroyed. Such an untoward event to a large extent would wreck the usefulness of the Academy, limit the possibilities of its service for the future and seriously restrict the activities of the entire medical profession of the city.

"Centering about the library as its nucleus, the Academy maintains continuous activities of a wide range and of diverse nature. Its public meetings and lectures give to the profession in New York the opportunity to hear the most distinguished men in medicine and surgery. In its sectional meetings, special questions of a particular branch of medicine or of a definite problem are illustrated and discussed for the information of those who are eager and willing to keep abreast of the medical knowledge of their day. Through these two means the Academy renders an enormous service in continuing the education of post-graduate students. Perhaps no other single agency touches more men desirous of study or offers them a more practical way of accomplishing this desire than The New York Academy of Medicine through its public and sectional meetings.

"Outside of these two agencies the Academy has conducted a Division of Public Health which has been in close contact with the health officials of the City and has served, not only to keep members of the profession in touch with public health problems, but has proved useful also in introducing to public health authorities the men able to advise and aid them.

"The Academy contemplates, as a part of its work, not only the immediate and direct service rendered through its library, its public meetings, its sectional activities, and its public health program, but it also endeavors to make itself a centre of professional information for the great number of men who resort to New York for medical training or for information as to where training can be had. It desires to make this a centre of information available for international purposes to the large number of foreign physicians and students who come to New York.

"The Academy,—if its building and its resources permitted,—would gladly extend a medical hospitality to individual physicians or to visiting medical societies that wish to hold sessions in New York City.

"In a word, the function of an academy of medicine in the city of New York contemplates not simply the facilities of a great library and the stimulation to the profession arising from interesting lectures and from fruitful sectional meetings, but it aspires to become an effective centre in the greatest city of the new world for those activities of medical men and of medical associations which are not now able to find in any one place either the information necessary for their right conduct nor yet the sort of welcome which the medical science of one continent should extend to the medical representatives of every other continent. New York City itself makes possible a medical centre, conducted by members of the profession itself, such as is possible in no other city of the new world and perhaps not in any city of the old. Not only is New York a city to which the medical men of North America constantly resort, but it is also the great port by which enter the physicians visiting us, whether they come from Europe, Asia, or South America. It is possible to establish in New York, therefore, through the Academy of Medicine, a centre that shall serve, not only the professional needs of those who teach and practice medicine in the City, but which shall also

serve as a clearing house for medical information, as an exponent of the relation between the medical profession and the public, and as a dispenser of that hospitality alike to the medical men of Buenos Aires, of Tokio, of London, or of Paris, the welcome of a city and of a nation; and which offers to them in one place such information as will enable them to find those opportunities which they seek. The function of an academy of medicine in the City of New York is, therefore, something far greater than the admirable work which the present Academy of Medicine is now carrying out.

"The financial situation of the Academy is set forth in a memorandum to be presented later. That memorandum shows that in addition to its valuable library and the small endowment raised through the efforts of medical men themselves, its chief asset is the building which it now occupies at 17 West Forty-third Street. It would be impossible to convert this into a fire-proof structure and quite impossible to enlarge it so as to accommodate an institution whose function is conceived in the terms of the preceding paragraph. Such a building should contain not only rooms for the library, for the general meetings of the Academy, for sectional meetings, for the Bureau of Public Health, and for professional information, but it must contain also facilities for professional associations and other medical organizations, for committee rooms, and for administrative offices.

"The property which the Academy owns is estimated to be worth some $450,000. An enquiry which has been made in the region between Forty-second Street and Fifty-ninth Street and between Fifth Avenue and Seventh Avenue indicates that a building site could be found within this area accessible and well-adapted to the needs of the Academy. Such a site would need to be not less than one hundred by one hundred and twenty feet. The sale of the present building of the Academy would provide a sum of money approximately sufficient to purchase such a plot. Tentative plans have been worked out as to the character and cost of a building necessary to house the library of the Academy and afford room for the activities which have been enumerated. The building should not be less than eight stories high. It should be fire-proof and should be so constructed that twenty-five years

from now additional stories could be added, if necessary. According to the sketches and estimates made by a reputable firm of architects it appears that such a building can be erected for about one and a quarter million dollars. These sketches can be seen at the office of the Academy of Medicine, 17 W. 43rd Street. This estimate seems as accurate as is prudent to submit until some definite assurance of the support necessary to carry out the plan just outlined can be obtained. A building erected under these conditions would not only house the library in fire-proof quarters, but would also furnish the requisite room for the students who use the library and who are now subjected to such crowding and inconvenience by reason of the lack of room as to greatly limit the use of the books by those who are engaged in research or serious study. It is believed, therefore, by the representatives of the Academy who have given this question thought that the sum mentioned, when added to that which could be realized from the sale of the present property, will effectively house the Academy of Medicine and make it possible for it to develop such a centre of medical influence and of medical co-operation as has been outlined in the preceding statement.

"In order that this program may be made possible it is, however, necessary that a certain endowment should be available for the specific purposes of the library, of the regional, national, and international bureau of information, and for offering to visiting medical men, whether from our own country or abroad, the facilities of a central agency of medicine. The annual payments of physicians and the gifts which are constantly made by medical men will be needed always to support the regular activities of the Academy. It is quite fitting and desirable that the medical profession should make this contribution, although beyond their power to furnish a great building or the funds for the support of a national and international centre.

"In view of the situation which has been briefly described in the preceding pages, the officers of the Academy of Medicine have the honor to earnestly request that the three great foundations to whom this appeal is made, and who have fostered more than any other endowed agencies the progress of medical education and of medical progress, will take under consideration the plan of devoting the sum of three million dollars, one million

from each foundation, to a fund which shall suffice to erect a building and provide an endowment for an international medical centre in the city of New York, to be conducted by the members of the medical profession itself through The New York Academy of Medicine. It is the belief of those in this academy who speak for the profession that no money which can be devoted to medical progress or to the betterment of medical education would do more to stimulate those agencies which bear most directly on the improvement of the practitioner in medicine after graduation from the medical school.

"It remains true that through the various activities of the Academy more practitioners of medicine are quickened and encouraged to a better understanding of their profession, to a more scholarly effort in the understanding of its problems, and to a more catholic spirit in dealing with other men in their profession, than is brought about through any other agency. In many ways an academy of medicine serves as an instructor of post-graduate medical men and it is the belief of those who present this appeal to the three foundations that the time has now come when their efforts to better medicine and to promote medical education may fittingly take the form of helping medical organizations themselves to render those services to the profession which can only come through medical organizations. We earnestly hope that this request, representing a mature conviction of the medical men in this vicinity as well as in some sense the medical men of the United States, may receive at your hands a most earnest and friendly consideration.

Respectfully submitted,

Geo. David Stewart,	Rufus I. Cole,
Edward L. Keyes,	Arthur B. Duel,
Walter B. James,	L. Emmett Holt,
W. Gilman Thompson,	Nathan E. Brill,
Charles L. Dana,	Hermann M. Biggs,
Seth M. Milliken,	Graham Lusk,
D. Bryson Delavan,	Samuel A. Brown,
Walter L. Niles,	William H. Park."

The letter of Dr. Stewart signalized the beginning of the third and final period of our story. Through the influence of the

Chairman of the Building Committee of the Academy it was brought to the attention of the Carnegie Corporation which, in 1922, voted a grant of one million dollars, afterwards increased by the sum of $550,000. With the new building thus made possible and with the generous support of the Rockefeller Foundation in the development and furtherance of the various educational facilities of the institution the immediate future of the Academy was assured and its further prospects rendered brilliant.

Prompt and courageous action already having secured a desirable location, the architects so long associated with the interests of the Academy were again retained, their plans accepted and the serious work of construction begun.

The By-laws which then existed placed the burden of administration on the president and the coordination of the Academy activities on the recording secertary.

The volume of work under the new conditions had assumed proportions far too great to be met by the unaided efforts of the already overtaxed officers of the Academy.

In recognition of this a new precedent was established in the creation of the office of "Director," the intention being to place the executive work in the hands of a competent leader who, under the supervision of the Council, should devote his time and energy to the general coordination of the activities of the institution and to the development of its various interests, especially such as were educational. On January 1, 1924, an appointment to this position was made.

Dr. Stewart, having accomplished the completion of the work preliminary to the actual construction of the new building, retired from the presidency in 1924, but by no means relinquished active participation in the Academy's affairs. The six years which marked his incumbency had been among the most important of the Academy's history, for during that time the idea of the expansion of the institution was promulgated in definite terms, the means for its fulfillment were secured and, the way having thus been made clear, the final execution of the work was begun.

He was succeeded by Dr. Samuel A. Brown, who assumed office in time to lend efficient aid in the numerous and exacting activities which attended the construction, equipment and organization of the new building. Dr. Brown presided at the laying of the cornerstone of the Academy, on October 30, 1925, and at the dinner given November 17, 1926, in honor of the twenty-two newly-elected Honorary Fellows of the Academy, thirteen of whom were from abroad. On this occasion, at which more than one thousand representative physicians were present, addresses were made by Dr. Harvey W. Cushing, of Boston, Dr. George E. de Schweinitz, of Philadelphia, Dr. William Sidney Thayer, of Baltimore, and by the Mayor of the City of New York, Dr. George David Stewart acting as toastmaster. Dr. Brown also presided at the exercises attending the dedication of the new building, on November 18, 1926.

Thus, from what has been presented herewith, we have seen that, following the patient efforts of many earnest men, through doubt, uncertainty and often disheartening delay, the time for effective action at last was recognized, with the result that the vision of seven years ago is the living reality of to-day.

We are proud of our precious new gift, unrivaled as it is among others of its kind, rich in the possibilities of its usefulness; and we are deeply grateful for the devoted self-sacrifice and the generous liberality which have so happily realized the dream.

But while admiring the structure in all its varied excellence and beauty let it be remembered that the building is but the treasure-house which contains that expression of our highest and noblest ideals,—the body, the life and the spirit of The New York Academy of Medicine.

COLONIAL MEDICINE, OR THE DOCTOR OF OUR FOREFATHERS

THOMAS J. HARRIS

(Delivered before the Section of Historical and Cultural Medicine, October 31, 1927.)

At the opening of the seventeenth century, Europe was only beginning to emerge from the darkness of the Middle Ages. Medicine had changed little since the days of Galen. It was still an art and not a science. Indeed it has been said that at the great Universities of Oxford and Cambridge, medicine at that period was not even a farce. The University of Edinburgh did not grant the degree of doctor of medicine until well on in the eighteenth century. We can form some idea of the doctor of the Colonies by a brief glance at his European contemporary. Dr. Francke H. Bosworth in his "Doctor in Old New York" (1) has written delightfully of this period. We quote from him as follows:

"The most prominent medical man of London was Sir Theodore Mayerne, physician to Henry IV and Louis XIII of France, and James I and Charles I of England. He was probably the most eminent physician of his time in Europe, and was a somewhat extensive writer on medical topics. With a shrewdness which has found many imitators, even in our own time among fashionable physicians, he made a specialty of the treatment of gout. Dr. Mayerne, however, recommended a most clumsy and inordinate administration of violent drugs. Calomel and sugar of lead, as well as pulverized human bones, were among his favorite remedies. The principal ingredient in his famous gout-powder was raspings of a human skull unburied. But his sweetest compound, as Jeaffreson tells us, was his Balsam of Bats, strongly recommended as an unguent for hypochondriacal persons, into which entered adders, bats, sucking whelps, earthworms, and the marrow of the thighbone of an ox.

"Another distinguished doctor of this period was Sir Thomas Brown, the erudite and famous author of *Religio Medici*. An-

other was the 'eccentric, gallant, brave, credulous, persevering, frivolous' Sir Kenelm Digby, courtier, cook, lover, warrior, political intriguer, and finally doctor. By means of his famous sympathetic powder some of the most marvellous cures in the history of medicine were accomplished. Curiously enough, the composition of this powder was revealed after the Doctor's death, by his chemist, and consisted merely of sulphate of lime which was obtained by a rather unusual but unnecessarily complicated process. Among others of this time were William Harvey who, unlike those we have mentioned, left to the world a bequest of incalculable value in his great discovery of the circulation of the blood; and Sydenham, one of the first to make available to his own and subsequent generations the value of intelligent clinical observation."

The leaders of the profession in London were distinguished for their literary ability. A delightful account of a half-dozen of these is found in a book printed many years ago called the "Goldheaded Cane" (2). The goldheaded cane was the emblem of authority of the doctor of those days, and this particular cane was carried by a number of them in succession and now reposes in the library of the Royal College of Physicians in London. One of the most eminent men mentioned in it was Dr. Richard Meade, who lived toward the end of the century and who is said to have had the finest art collection and the largest private library in London.

For a long time after the days of Galen, medicine was largely in the hands of the priests. "The doctor of the 17th century in England and the Continent wore a long black gown and skull cap, a modification of the robe of his priestly predecessor. He wore a wig which was adorned with either two or three tails and was so elaborately dressed that he often went bareheaded through the streets of London lest it should become disordered. His silk coat and stockings and his silver buckles seemed to have been essential parts of his dress, and even a muff, to preserve the softness and delicacy of the hands, was carried by many. Up to the days of Charles II he made his visits on horseback, riding sideways after the fashion of women, but after that time he rode in his coach, drawn by two, and sometimes four and even six

horses." "His 'armamentarium' consisted of certain simple compounds together with a few minor remedies. While herbs, required to be gathered in certain phases of the moon or conjunction of the planets were employed, both and above all, his lancet was his main reliance and he seemed to have used it on all occasions." Like father like child, such being the state of medicine and of the medical practitioner in the old world, what else could be expected of the art and the artist when transported to the new world! Medicine during the early days in the colonies received scant consideration. Few doctors accompanied the early settlers to this country. In Virginia, Capt. John Smith had with him two or three doctors of reputation, for a time. William Penn also brought to Pennsylvania one or two reputable practitioners. Samuel Fuller, a passenger on the Mayflower, was the earliest practitioner in Massachusetts. He was a deacon but is continually referred to in the records as the surgeon of the Colony though not a graduate of medicine. In the Colony of New York there were several graduates in medicine from Utrecht, the great Dutch medical center, who came across with the original settlers or followed them shortly. Most of these returned before or at the time the colony became an English possession. The first of these who made his appearance in New Amsterdam was one by the name of Johannes LaMontagne (3), a learned Huguenot gentleman, who arrived in the Spring of 1637. He was born in 1595 and received his degree from the University of Leyden. In addition to being the doctor of the colonies, he was the schoolmaster. He also occupied a seat in the Council, and as Vice-director in command of Fort Orange he surrendered the Fort when the English took possession. He is supposed to have returned to Holland with Governor Stuyvesant in 1665. For the most part the colonies, outside of one or two cities like Philadelphia and New York, were without medical graduates. When one considers how sparsely the country was settled and consequently what few inducements there were to bring medical graduates across the seas, this is not surprising. For the first one hundred years or more, much of the medical care in the colonies was supplied by the clergy. They were almost without exception highly educated. Many of them

preparatory to coming to America had studied medicine on the other side. The rôle of doctor had been played by the priests for many centuries in Europe. In the absence of medical men what could be more natural than that the guardians of men's souls should assume at the same time the care of their bodies! In Connecticut no physician accompanied the first colony to Hartford in 1636. Mr. Hooker, the leader, had some medical qualifications, but in times of epidemic there must have been severe suffering. The first practitioner in Connecticut was Thomas Pell, born in Sussex, England, in 1613, to whom the General Assembly granted liberty "to buy all the lands of the Indians between Westchester and the Hudson River." The purchase included a large tract of land later called the Pelham Manor. Here Pell lived and transacted business although he died in Fairfield, Connecticut, in 1663. A distinguished practitioner of medicine in New England was Rev. Gershon Bulkeley (4), of Weathersfield, Connecticut, who lived during the middle of the seventeenth century. He graduated from Harvard in 1655. He was for a time minister of the Weathersfield church but later devoted himself entirely to medicine. An interesting description of one of the doctors of those days is found in an account of "Dr. Thaddeus MacCarty, a New England Country Doctor of Pre-Revolutionary Days" (5), written by one of his descendents. Dr. MacCarty was born in Worcester in 1747. He was a graduate of Yale, having as one of his teachers who prepared him for college, John Adams. From the record he has left, it does not seem that the future president of the United States was particularly distinguished as a teacher; certainly he spent most of his time in day-dreaming, possibly contemplating the stirring scenes through which he was to pass a little later. Dr. MacCarty, like so many others, acquired his knowledge of medicine by studying with an older physician. He first resided in Massachusetts and later in New Hampshire. His biographer, commenting on the conditions under which he had to practice medicine, says: "It is scarcely possible in this day of improvement to form any adequate idea of the labors of these men. There were no roads, nothing but the rivers. The doctor kept four or five horses and having constant calls, kept himself and the horses in perpetual

motion. I have often heard him in after life relate the toils and adventures of this period and how many narrow escapes he had of broken neck and limb. In one instance, when his horse was in full trot on a winding road through the woods on a very dark night, he ran his head full butt against a tree. Both he and the horse were prostrated on the ground."

Clergymen continued to act in the capacity of doctors down to the beginning of the last century. One of the best-known physicians in eastern Pennsylvania was a minister by the name of Matthew Wilson, born in 1734, who practiced medicine until the time of his death in 1790. A book written by him entitled "A Therapeutic Alphabet" (6), showed that he had good sound medical knowledge as well as good common sense. He never graduated in medicine. Medical men did not confine themselves always to their profession but with it often combined some form of manual work. Their charges, considering the long distances and poor roads they had to travel over, were surprisingly small. An extract from the account of one Jasper Gun, who practiced medicine in Connecticut, dated April 16th, 1659 (7), is as follows:

Due from Fra Barnard for her girles

For a dose of pills	02
For 6 doses of pul diat	12
For castor, 18 doses	9
For vissites, 25 times	12
For purge of Rhubarb	02
Received of him in coine	16
in butter	

Medicine would seem to be much more highly valued than "journeys or visits" as they called them. In the same entry there is a charge for "my 'too' journeys, 8 shillings."

The earliest book on medicine appearing in the colonies was a little pamphlet entitled "Medical Directions Written for Governor Winthrop" by Edward Stafford of London (8). On it appears the notation "Prepared for the benefit of Governor Winthrop here in New England. The original collection of receipes made in 1643 by some London physician." This was

reprinted in 1862 with notes by Oliver Wendell Holmes. Some of the prescriptions are most amusing. For madness, he was directed "To take ye herb hypericon (St. John Wort); for pains in ye breast or limmes, wear a wilde catt's skin on ye place grieved" while for the "King's Evil" (Smallpox) Governor Winthrop is advised "to use two toads, letting them rest two or three days that they spewe out their earth."

The learned London doctor adds that by this course there is no doubt of the cure by God's assistance. Commenting on this remedy Dr. Holmes speaks of the reference to toads in Boccaccio and in Shakespeare.

"That they were 'ugly' as Shakespeare says, none will dispute. That they were 'venomous' may perhaps be questioned. That they wear 'precious jewels in their heads' must be confessed a fiction. Boccaccio's story of Pasquino and Simona may not be remembered by all my readers. The first who was the lover, seated near his ladylove, plucks a leaf of a bush of sage, swells up and dies. The ladylove does the same thing and also dies. Under the sage was found a monstrous toad."

There are twenty-three references in Shakespeare to "toads" including the one which Dr. Holmes quotes, from "As You Like It." They all give the impression that the toad was an obnoxious animal to be hated, if not to be feared.

Dr. Holmes, in his delightful way, dwells on the remedies recommended in this quaint little book, only six by seven inches in size, as indicative of the treatment that our forefathers were wont to receive. He points out that few of them were to be taken internally and most of them sought to accomplish what the medical men of to-day strive for, *i.e.*, removing from the system in one way or another, the poison that it contains. Governor John Winthrop, to whom the book was sent, was the most distinguished physician of his time in New England. He was born in 1606 in Groton Manor, England, and studied at Trinity College, Dublin, and law at the Inner Temple, and came to this country with his father, Governor John Winthrop, of Massachusetts. He was Governor of the Connecticut Colony from 1651 to 1659. In 1662 he visited England and was elected a member of "The Royal Society for Improving Useful Knowledge," which had been estab-

lished the year before. While there he contributed a number of valuable papers to the Society. His advice was sought far and wide through New England. He appeared to be the great consultant of the New England Colonies. He devised a medicine called Rubila, which had an extended reputation. It was not known for many years what this consisted of, but finally the formula was found and it proved to be a mixture of antimony, nitre and a little salt of tin. It seemed to be a general cure-all.

Just as Governor Winthrop was the most distinguished medical man of the seventeenth century in the colonies, so Benjamin Franklin was the most famous doctor of the eighteenth century. Franklin never received a degree in physic, although it was so generally believed that he had, that several of the best engravings of him are inscribed, "Benjamin Franklin, Doctor of Medicine." While this is true, Franklin possessed more medical knowledge than almost any man of his time. His inquiring mind took him into many lines of medical research including the application of electricity to disease. He wrote numerous articles upon medicine and was the founder of the Pennsylvania Hospital, of which he was the first president. Franklin's advice was sought on all sides—indeed medicine formed such a considerable part in his life that Dr. William Pepper has written a most interesting book on "The Medical Side of Benjamin Franklin" (9).

Another early contribution to medicine was written in 1677 by Dr Thomas Thatcher, also a clergyman, called a "Brief Rule to Guide of the Common People of New England, how to order themselves and others in the 'small pocks' or measles" (10). Smallpox both in Europe and in the Colonies was one of the most common and most fatal diseases. Our forefathers were a sturdy lot of men and women who required little medicine. They were more concerned with the salvation of their souls than with the preservation of their bodies. Indeed, that their souls might not suffer, they had scarcely reached here before they founded an institution of learning at Cambridge, Mass., where men could be trained for the ministry.

Medicine was not solely in the custody of the minister, however, because, as we have just seen, Governor Winthrop, of Connecticut, as well as his father, Governor Winthrop, of Massachusetts, had an established reputation for medical skill.

The medical profession bore an honorable part professionally and otherwise in the Revolutionary War. Major-General Joseph Warren, who lost his life at the Battle of Bunker or Breed's Hill, was a distinguished physician. The leaders of public sentiment were largely from among the physicians of the colonies. Of the signers of the Declaration of Independence the following were physicians:

Josiah Bartlett, of New Hampshire
Matthew Thornton, of New Hampshire
Oliver Wolcott, of Connecticut
Benjamin Rush, of Pennsylvania
Lyman Hall, of Georgia.

Many of them were men of liberal education, graduates of colleges at home and abroad. Many without these higher advantages were the peers of their associates in intelligence. With very few exceptions they were earnest patriots. The most influential of them were men of decided religious character, members and officers in their local church.

In the first hundred years or more in the colonies there were few if any laws governing the practice of medicine. As a result there was abundant opportunity for quacks to apply their trade to the misfortune and detriment of those whom they attended.

The most renowned of all these quacks, in fact probably the most famous quack that America ever produced, was Dr. Elisha Perkins (11), of Plainfield, Connecticut. Dr. Perkins was born on January 16, 1741, and is said to have studied at Yale (this is doubtful). He was the son of a well-known doctor of Plainfield and practiced medicine himself for a number of years until he devoted his entire time to the manufacture and sale of his famous metallic tractors. These were employed on the theory that metallic substances had an influence upon the nerves and muscles, because Perkins had noted once during an operation a certain contraction of a muscle whenever the metal instrument was brought in contact with it or was drawn or stroked over the affected parts. They consisted of two rods or pieces of metal about three inches long, seemingly of brass or iron, similar to a horse shoe nail, rounded at one end and pointed at the other. The

most distinguished men in the nation testified to their value. Perkins went to England and made enormous returns by selling them. He returned to this country to perish from yellow fever, for which he had made use of his tractors in endeavoring to cure himself. His son, a graduate of Yale, carried on their manufacture for many years. Since Perkins' day many other quacks have arisen, including only recently Abrams, with his diagnosis of disease made by studying the blood cells. No one, however, has ever attained the fame of Perkins.

Dr. William Douglass, who settled in 1718 in Boston, says in his "Settlements in North America" (12) regarding the practice of medicine in the colonies: "In our plantations a practitioner bold, rash, impudent, a liar, basely born and uneducated has much the advantages of an honest, modest gentleman. In general, the physical practice in our Colonies is so perniciously bad that excepting in surgery and some acute cases it is better to let nature take her course than to trust to the honesty and sagacity of the practitioner. Our American practitioners are so rash and officious that the saying of the Apocrypha may with propriety be applied to him: 'He that sinneth before his Maker let him fall into the hands of the physician.' When I first arrived in New England, I asked a noted and facetious practitioner what was their general method of treatment. He told me it was uniformly bleeding, blistering, purging, anodynes, etc. If the illness continued, there was repetendi and finally murderandi." We have often admired the courage of our ancestors, but in the light of this we scarcely have given them credit enough for the way that they bore their sufferings.

During the Dutch occupation of New York, the care of the sick was largely entrusted to a class of experienced nurses called "Zieckensroosters" or "comforters of the sick." The care of the women in childbirth was entirely in the hands of midwives and continued so, well into the eighteenth century, the custom preventing any male physician from officiating. Three of the famous midwives in the Dutch Colonies were Lysbert Dircksen (1638), Tryntje Jansen and Annetze Jansen, the last of whom, as you may recall, owned or inherited much of what is now Manhattan Island.

At the opening of the Revolutionary War it is estimated that there were 3,500 medical men in the colonies, not more than 400 of whom were graduates of medical schools. Among these, Edinburgh was conspicuous for the number of its distinguished graduates. The founders of the University of Pennsylvania, Morgan, Shippen, Rush, were all graduates of that famous university. The first medical diploma awarded by a university in this country was awarded by Yale University to Dr. Daniel Turner, of London, in 1723. The circumstances under which this was awarded are interestingly told by John E. Lane in an article on the "Annals for Medical History for 1919" (13). Turner was born in London in 1667. He was a member of the Guild of Barber Surgeons. "The doctor of the seventeenth century was either a chirurgeon (contracted into surgeon in the eighteenth century), physician or barber-chirurgeon, the designation of doctor not coming into use in America until about 1769. This association of the surgical and tonsorial art seems very curious to one living in the twentieth century, but it arose in a very simple and natural way. Physicians have been known in history from the earliest recorded times. A chirurgeon (from the Greek words, *xeir*, hand, and *epyov*, work) seems to have been at first merely an assistant of the physician, performing for him various minor duties. This condition existed through the days of Greek and Roman civilization, but during the Dark Ages the practice of medicine in Europe fell almost entirely into clerical hands, and the duties of both physician and surgeon were performed by the priesthood. Certain abuses crept in which led the ecclesiastical authorities to interfere and forbid the clergy from practicing outside their monasteries. And again, as we find recorded in various Councils of the Church during the ninth and tenth centuries, the shedding of blood by the clergy as in surgical operations was absolutely interdicted. In order to retain their practice they were in the habit of sending out their barbers to perform blood-letting and other of the minor operations in surgery. By that time the shaven priesthood had come into being, and the barber was an attaché of every monastic institution. As we can readily see, these monastery barbers very soon began to practice independently. As they grew in number and strength they became incorporated into special crafts, that of the barber-surgeons of England being regularly chartered in the

fourteenth century. This institution became one of the wealthy corporations of London, and flourished for four centuries, and it was not until 1745 that it became separated into two crafts, that of the barbers on the one hand, and the surgeons on the other."

Turner was a man of distinction in medical circles in London and no doubt felt that he was at a distinct disadvantage in not being a physician. This, one could not usually become without being a graduate of one of the great universities, Oxford or Cambridge. Turner was a graduate of neither. He could have probably gotten a degree from Edinburgh, but Edinburgh at that time was not in favor because of certain questionable practices in the matter of bestowing degrees. He was acquainted with the rector of Yale University and through him presented to Yale a collection of medical books which are still to be found in the Yale library. This prompted him to apply to Yale for a degree in physic. His degree was entirely an honorary one. Turner never came to this country. For two hundred years surgeons like Turner strove to separate from the barbers but without avail till 1745, five years after Turner's death. The Royal College of Surgeons was chartered in 1800.

The first medical school in this country is that of the University of Pennsylvania, which was founded in 1765 and which graduated its first class of eighteen men in 1769 with the degree of Bachelor of Medicine. The first degree of Doctor of Medicine after a course of study, was bestowed by the Medical School of Kings College, City of New York, now the College of Physicians and Surgeons of Columbia, upon Robert Tucker in 1770.

The medical department of the army was organized by and had as its first director Dr. Benjamin Church who was succeeded by the distinguished Dr. John Morgan, of Philadelphia, the founder of the Medical School of the University of Pennsylvania. He was succeeded in 1777 by Dr. William Shippen, Jr., also a professor in the same university, who served in that capacity till 1781 when he was succeeded by Dr. John Cochran. The army hospitals were for the most part improvised structures. In Cambridge, during the siege of Boston, several of the private houses were turned into hospitals, and churches especially, for a number of years were used for that purpose. A letter from Dr. Morgan to Dr. John Warren, the brother of the famous Gen-

eral Warren, who lost his life at Bunker Hill, will best explain the serious difficulties under which the department operated.

"I send you two scalpels; in case you want more, use a razor for an incision knife. I have a handful of lint and two or three bandages, that is all. What in the name of wonder can I do in case of an attack. God only knows. Without assistance, without instruments, without everything." Think of that from the Surgeon-General of the United States Army! In a later letter he complains of having too few regimental surgeons and too frequently those whom he had were incapable of doing their work. At one time he had two hundred ill with no doctor to attend them. Lack of food and proper protection against the weather took off many of those who were sick. Indeed, it is probable that more lost their lives from disease than from wounds. A happy exception to the incompetency of the crudely-educated army surgeon was Charles Frederick Wiesenthal (14), who was born in Prussia in 1726 and after a thorough medical education came to this country and settled in Baltimore. He took a high professional rank among the practitioners of the South and during the war served as a surgeon with the Maryland troops. The description of the dress of Dr. Wiesenthal throws an interesting light on the appearance of the better class of medical men in those days. Dr. Wiesenthal wore a scarlet cloak, three cornered hat, blue velvet coat, gold buttons with buff facings, lace ruffled shirt, knee breeches, stockings, white or blue, silver shoe buckles, plain white cravat, wig and cue tied with a black ribbon. This was not without objection from medical men of those days. We are told that "some of the physicians of New York entered into a contract to distinguish themselves from their fellow citizens by a method of wearing their hair. Among the rest, it was proposed to Dr. John Jones, one of the most distinguished physicians of the time, whose father and grandfather were physicians before him. He indignantly and properly declined to enter into such an arrangement, declaring that he considered that and every similar means to impose upon the weakness or credulity of others, as unworthy the members of a liberal profession, and as intended to enforce that attention and respect which their own conduct and abilities should always command. While the other doctors in the town, therefore, were strutting about in the new-fashioned bob, Dr.

Jones could not be distinguished from any well-bred gentleman of any other profession. Of course an attempt was made to boycott him by a plan not altogether unfamiliar to physicians now living, namely, by refusing to consult with him. The result was as might have been expected; on the first occasion in which this plan was brought into practice the physician who refused to consult with Dr. Jones was promptly dismissed, and Dr. Jones installed in his place." Dr. Jones was a graduate of the University of Rheims. Upon his return to New York he was made Professor of Surgery in the College of New York. He became a warm personal friend of both Washington and Franklin. He died at the age of sixty-two.

Conclusion

Such is the story of the doctors of our forefathers. Would that we possessed the magic pen of a Washington Irving to narrate it as it should be given. The medical profession to which as student and practioner we have belonged for nearly forty years is to us the noblest of all callings, the ministry not excepted. You all are acquainted with the charming description of the old country doctor by Ian MacLaren in his "Beside the Bonny Briar Bush" (15). What is more touching than his account of the old Scotch physician as he made his way on horseback o'er hill and down dale with his simple remedies in his saddle bag, bringing with him what is far more efficacious than any drug, the reassuring confidence found in his homely countenance? He may not have possessed the learning of an Osler nor even the knowledge which his city colleagues of that day possessed, but what was far more valuable he brought with him knowledge gained of experience, sound judgment and above all a heart of sympathy and love. What greater assets can a physician bring to our bedsides to-day! The respect accorded the minister and doctor in the community a hundred years ago no longer is shown them. We live in a totally different age. It is no longer aristocracy but democracy which controls. The physician of to-day is not called upon to take the arduous journeys or to undergo the hardships of his colonial predecessor.

However deserving he is of this lessened respect, there can be nothing but admiration for his noble predecessor of two hundred years ago.

We conclude with this fine tribute from the "Recollections" (16) of the late Vice-President Thomas R. Marshall:

"I think, if service is to be the true mark of greatness in a people, all these other wonders of a wondrous age and state must pale into insignificance beside the service and sacrifice of the country doctor. Who now remembers the conditions under which he sought to minister to minds and bodies diseased? Who now, by any stretch of the imagination, can bring to view the awful roads, the inhospitable houses that were called homes, the lack of furnaces, bathrooms, hot water, electricity, gas; mud everywhere, cracks in the houses everywhere, children waking in the morning with their blankets covered with snow, huge fireplaces where you roasted on one side and froze on the other? And add to it all a malarial climate. Chills and fever—fever and chills. Day in and day out, night in and night out, storm and sunshine, the country doctor went his rounds."

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ABSTRACTS OF PAPERS PRESENTED AT SECTION MEETINGS

Section of Surgery, October 7, 1927

POST-OPERATIVE COMPLICATIONS OF SUPPURATIVE APPENDICITIS

CONDICT W. CUTLER, JR.

This paper reviews the post-operative complications of suppurative appendicitis as seen in a fairly busy surgical service over a period of five years

During this space of time, in a total of 974 cases of acute appendicitis, there have been treated at The Roosevelt Hospital from January 1, 1922, to January 1, 1927, 392 cases of suppurative appendicitis. From this group are excluded all such cases as have been classified either as chronic or interval appendicitis. Excluded also are those cases, 582 in number, classed as acute appendicitis, in which no suppurative process was present at operation or later supervened. The rather restricted group which remains comprises those cases in which definite suppura-

tion requiring drainage was present. These cases showed empyema or gangrene of the appendix (either partial or complete) or perforation, or marked exudate, and were associated with more or less widespread peritonitis or with abscess. It was in this group that complications of the disease were most frequently encountered and proved of the most vital consequence. There were 83 cases, or 21 per cent. of this series which developed complications.

Reviewing these cases with reference to the pathology encountered at operation, it was found that 290, in addition to the pathology of the appendix itself, had a local peritonitis or periappendiceal abscess, while 102 had diffuse peritonitis. As to the results of treatment in the 392 suppurative cases, 337 were discharged cured, 14 improved, while 41 died. These figures represent a mortality from all causes of 10.5 per cent. of the drained cases (and 4 per cent. of all acute appendices).

In the treatment of these cases, the diagnosis of acute appendicitis was considered the indication for immediate operation. At operation, following a cleansing enema, shave and iodine preparation, the right intermuscular incision was the approach of choice. The appendix was removed in all cases except where its extirpation was hindered by a need for shortening the operation on account of the patient's condition, or by the danger of spreading septic material in the peritoneal sac by excessive manipulation. The stump was inverted whenever possible. Gangrene of the appendix, rupture, or the presence of a purulent exudate were the indications for drainage. Suction was uniformly employed to remove carefully all obtainable septic exudate.

The post-operative complication which, in this series, gave the greatest concern and was responsible for 63 per cent. of the total mortality was that of peritonitis. When, in these cases, it became evident that a spreading peritonitis had developed or had not begun to subside after operation, it was the policy of treatment to discontinue all nourishment and fluid by mouth, to keep the patient in Fowler's position and to administer normal saline solution by hypodermoclysis, or saline in glucose by vein, and tap-water by rectum. Morphine was used for the control of pain and to insure quiet, but not to the extent of full narcoti-

zation. Instead of favoring "bowel-splinting" it was the policy of treatment to stimulate bowel elimination with the objects of avoiding the toxic effects of ileus and of controlling distention. To this end colonic irrigations were employed, usually in conjunction with pituitrin hypodermically. Ox-gall and milk-and-molasses enemas were also used, and hot stupes applied to the abdomen. Lavage was resorted to to control vomiting and gastric dilatation. Transfusion as a means of general support has been found of value in a number of the cases.

Of the 102 cases classified as having diffuse peritonitis at operation, 71, or nearly 70 per cent. controlled the disease and went on to recovery under this treatment, while 27 proceeded with fulminating peritonitis. In addition, four cases of diffuse or generalized peritonitis developed following operation on cases in which a more or less localized abscess was found. Of the total of 31 cases in which this complication of peritonitis developed or was not controlled 26 died. The five who survived raise the recovery rate in all cases of diffuse peritonitis to 71.7 per cent., almost the exact figure reported by Fowler in 1911.

High enterostomy was performed for paralytic ileus in five of these cases on the second and third days. One recovered.

The second post-operative complication in order of frequency in this series was secondary intraperitoneal abscess. This complication developed eighteen times in the 392 drained cases, or 4.6 per cent. The development of these abscesses was usually signalized by the failure of the temperature to subside, or by its recurrence, attended by pain, more or less distention and the presence of tenderness or a palpable mass. Ten of these abscesses were successfully drained through the original operative wound. The remaining eight required operation for relief. Of these, four were subphrenic abscesses, two were in the right lumbar gutter, two subhepatic and two were in the left lower quadrant.

Of the eighteen patients developing secondary abscesses five died, including two of the four subphrenic cases. The two subphrenic cases which survived were drained by rib resection. Here, as in the instance of general peritonitis, multiple complications played a part in the mortality.

The plan of treatment followed in these cases of secondary abscess was to await the definite localization of the abscess mass, then to approach it for drainage by the shortest feasible route. In three cases spontaneous drainage occurred through the wound.

In this series there were five cases of fecal fistula, or about 1½ per cent. There were no fatalities. Three of these fistulae closed spontaneously, two requiring secondary operation for repair. Three of the fistulae occurred as complications of secondary abscesses, the remaining two developing at the wound site.

As a measure to prevent the possible development of fecal fistula by gut necrosis from drain pressure, daily shortening of the drains by an inch or more was the practice. Once the tract was well established the drains were usually removed entirely from the fourth to the eighth day after operation.

Mechanical ileus as a subsequent complication of these drained cases occurred five times in the group under study (1.3 per cent.). One such complication developed in a case with diffuse peritonitis and secondary subhepatic abscess. An enterostomy was done on the twenty-seventh day with recovery. Another recovered following drainage of a secondary abscess on the ninth post-operative day. Of three cases of ileus which developed as a result of adhesions following diffuse peritonitis, one recovered after division of adhesions, one after ileostomy, and one died after a colostomy done a month following the original appendicectomy.

None of the patients returning to our follow-up clinic have given evidence of frank obstructive symptoms as a late complication, although there have been a number complaining of constipation. As a routine following recovery from peritoneal inflammation, laxative diet and the use of mineral oil have been advised.

Cellulitis of the abdominal wall with abscess formation occurred in three cases. These recovered satisfactorily following drainage. There was one case in which rather wide sloughing of the wound required skin grafting for repair. During the past two years we have adopted the suggestion of Pool advising against the suture of these drained appendicectomy wounds beyond the parietal peritoneum. While no statistics can be

quoted from our records on this point, we have been impressed by the fact that we see much less sloughing of muscle and fascia than when suture was done, and that the unsutured wounds granulate more satisfactorily and heal more rapidly. This applies to the intermuscular incisions, as we have not ventured to leave our rectus incisions unsutured.

As to the late result in drained wounds, the recall clinic has produced six post-operative hernias, or 1.5 per cent. None of these occurred in unsutured cases. Of the six hernias four occurred in intermuscular incision scars and two in rectus incisions. Since the reported figures for post-operative hernia in especially-followed groups is much higher than in this series, it is fair to suppose that there have been other cases of hernia which have not returned to our follow-up clinics.

As a measure of prevention against post-operative hernia it has been the custom to advise the wearing of a supporting belt for at least six months after operation in the drained cases.

Of the incidental complications in these patients there were a number. Diabetes was present in three, with two deaths. One of the fatal cases had diffuse peritonitis and died on the sixth post-operative day. Insulin was used in this case. The other death occurred in a patient 66 years of age, with severe nephritis besides the diabetes. No insulin was employed. The case which recovered improved following appendicectomy with drainage of an abscess under the use of insulin. Abortion in pregnant cases occurred three times in the series with two deaths. These fatal cases both belonged to the general peritonitis group. The recovery followed miscarriage on the ninth day after appendicectomy and drainage of an abscess. Uremia was noted as occurring twice in elderly patients, once in a spreading peritonitis case and once following the drainage of an abscess. It proved fatal in both instances. No record of parotitis was found in the group under study.

Pulmonary complications, pneumonia or bronchitis, developed post-operatively in eight cases (about 2 per cent.) and resulted in two deaths. Empyema occurred in one case. Pulmonary embolism resulted in one fatality on the fifth post-operative day, while the one other patient in whom this accident occurred made a good recovery.

Review of this group of cases presenting post-operative complications in suppurative appendicitis presents several features which are perhaps worthy of comment. Pulmonary inflammations accounted for one-tenth of the complications. Abdominal wall infection was infrequent, and sloughing was apparently less in unsutured wounds. Post-operative hernia was rather infrequent, being relatively much less common in intermuscular than in rectus incisions. Mechanical ileus was rare, accounting for but one death in the series. Fecal fistula was not a prominent complication, and in but two instances was it possibly ascribable to the presence of drains in the wound. Spontaneous closure was the rule. Next to spreading peritonitis, secondary abscess was the most frequent complication. The majority of these were within reach of the wound. Of the remote secondary abscesses, those of the subphrenic type proved the most grave. The presence of an intercurrent uremia, diabetes, or pregnancy constituted a grave handicap to the patient suffering from severe intra-abdominal infection. Uncontrolled or progress-peritonitis remained, as it has always been, the least responsive to treatment, the greatest menace to the patient, and the most trying problem to the surgeon.

Section of Otology, in Conjunction with the New York League for the Hard of Hearing, October 14, 1927

FAKES AND FADS IN DEAFNESS CURES

(Abstract of illustrated talk.)

ARTHUR J. CRAMP

Quackery is always plausible and credulity is not necessarily a sign of low intelligence. We are all credulous when we wander in strange fields. The number of quacks and faddists who defraud and deceive those who cannot hear, or who hear with difficulty, is large, considering the restricted field in which they work. Most of the practitioners in this line are crude charlatans; a few possibly come within that "twilight zone" of medical practice where it is difficult to differentiate between the quack with a scheme and the visionary with a theory.

Some deafness-cure quacks carry their alleged cures merely as sidelines to other medical fakes. Some sell elaborate but worthless courses of treatment; others dispose of devices that are always valueless and, frequently, dangerous. Still others, physicians of mediocre ability, are itinerants who stay usually not more than twenty-four hours in one place.

Some time ago a quack at Kansas City, Missouri, exploited an alleged deafness cure through the mails. He had an "electro-magnetic head cap," which was said to revivify the nerves, some strychnine tablets, some ear drops containing glycerine and carbolic acid, and a gargle. The postal authorities finally put an end to this business by declaring the thing a fraud and debarring it from the use of the United States mails.

More recently there has been another fraudulent deafness cure exploited from Kansas City. It was known as "Virex," and previously had been called "Rattlesnake Oil." It, of course, contained no rattlesnake oil. Not that it would make any difference if it had. What it did contain was some oils of eucalyptus and camphor, Neatsfoot oil, and oil of mustard. The postal authorities got around to this fake and declared it a fraud.

There are on the market a number of so-called artificial ear drums or ear phones. They are both worthless and dangerous. There are also oils that are sold to be applied to the back of the ears, for the purpose of curing deafness. One of these was seized by the government officials on the charge that it was misbranded under the Food and Drugs Act, because the claims were false and fraudulent. The court upheld this charge and ordered the product to be destroyed.

Deafness-cure quackery, like all other forms of quackery, will continue to flourish just so long as the public is ignorant of the facts. Again, it must be emphasized that it is not so much a lack of intelligence as a lack of knowledge that makes people credulous. The quack who knows how to word his appeal can gull the intelligentsia as easily as he can convince the illiterate. It was Talleyrand who boiled down the philosphy of the quack: "To succeed in the world it is much more necessary to possess the penetration to discover who is the ignoramus than to discover who is the wise man." The best that the medical pro-

fession can do in protecting the public is to turn the light on the methods of the faddist and the quack, so that his ignorance or fraud becomes apparent.

Section of Ophthalmology, October 17, 1927

LOSS OF VITREOUS

ISAAC HARTSHORNE

The method of teaching usually used by the late Maurice Richardson, of Boston, always impressed his students with its practical advantages. He spent most of his time in the lecture room telling us about his mistakes and seldom if ever mentioned his successes.

In this same vein of thought, I wish to record three cases of extreme loss of vitreous, with the hope that a statement of the errors helping to cause this unfortunate accident, together with a description of the after care which doubtless contributed largely to the unusually happy results in two of the three cases, may help someone else under similar circumstances. I do not in any way wish to appear to condone vitreous loss nor to lessen any younger surgeon's healthy respect for the vitreous.

These were all private patients, aged 64, 70 and 63, respectively; 1st, male; 2nd and 3rd, female.

Two of these cases are taken from the series of my modification of the Barraquer-Green intracapsular operation and will be detailed again in a future report of this type of operation. The third was an attempted capsulotomy

The first two were so similar that they can be discussed as one case. Deep intra-orbital anesthesia, after the method of the Greens, and infiltration of both the upper and lower lids were used so that the patient could not voluntarily close the eyelids and could not rotate the eyeball to any extent. This precluded the possibility of squeezing. That I am no longer in favor of this type of anesthesia and have given it up will be discussed at some future time.

In each case the vacuum cup was applied and took hold of the lens perfectly and there was no presentation of vitreous before the lens was extracted in capsule. In each case immediately after the withdrawal of the lens the wound gaped widely and at least a third of the vitreous rolled out before the eye could be closed. The upper lid was then gently lifted away from the globe with a muscle hook; and with a flat spatula, as much of the escaped vitreous as possible was wiped away from the wound and the corneal edge of the wound placed in contact with the scleral edge. One per cent. noviform ointment was put in the eye and the eyes closed and routinely covered.

Both of these cases were among the earlier ones in my efforts with the vacuum operation. In trying to combine pressure below the cornea with traction from above, the prolonged pressure caused the wound to gape instead of closing, after the removal of the lens. This explanation was suggested to me by Dr. Alfred Wiener, who was present at each operation, and I believe it is correct. This led me to discard the special instrument used by the Greens for this purpose and to use instead the combined Fisher needle and Smith spoon. With the needle the cornea is lifted so that the vacuum cup can be inserted under it. Turning the instrument end to end in the left hand, the edge of the spoon is then used to produce gentle and almost negligible pressure below the cornea while the traction from above withdraws the lens. The upward motion of the right hand holding the vacuum forceps is followed by the left so that the flat of the spoon holds the cornea in place and the wound does not gape. Since adopting this procedure, I have had no loss of vitreous at this stage in the operation.

After finishing the first of these operations, Doctor Wiener remarked that I would take that eye out in a few days. Six months later I asked him to examine this eye and he said: "All I can say is that it is not the same eye."

The third case was a hard lens with adherent capsule which did not look fully mature. This patient was from beginning to end the worst squeezer I ever had. When I get another like this I shall certainly use a general anesthetic. Up to the time to operate I had expected to do a vacuum intracapsular but her bad

squeezing made me decide to do a capsulotomy. Both upper and lower lids were infiltrated with 2 per cent. novocain, which reduced the squeezing to a minimum, but she still seemed able to push the eyeball forward without closing the lids.

The cystotome apparently made no impression on the lens capsule. When I attempted to express the lens by pressure from below as if I were doing a Smith extraction, the zonule broke at the top of the lens, allowing vitreous to present, but in another second the lens came upward without tumbling and filled the wound so no vitreous was lost at that stage. Here, again, after the lens was extracted the wound gaped widely and at least one-half of the vitreous rolled out, and even after closing the eye the whole vitreous body seemed to fill the wound and kept the cornea from going back into place. After some coaxing with a flat spatula and holding the upper lid with a muscle hook, I succeeded in tucking the corneal edge of the wound up under the scleral edge, as that was the nearest to coaptation I could get. As I expected a collapsed eyeball, this at least could do no harm. Routine dressing to both eyes as if nothing had happened.

In the first two cases I did not use a flap. In this case I had dissected a Van Linte flap but could not pull it into place because of the partially collapsed eyeball. This would have been a good case for Beren's untied suture flap, but this type of flap in my hands has interfered with my section, tending to make me cut too deeply, so I do not use it.

Suggested improvements in the third case are several:

First.—A general anesthetic might well have been used. And yet if this precaution had been taken she squeezed enough at each dressing to ruin any eye.

Second.—Too much pressure below the cornea in the effort to rupture the zonule will cause excessive gaping of the wound.

Third.—This might have been a good case for the Knapp-Török operation.

Fourth.—When the zonule breaks above so that vitreous presents, it is safer to use a wire loop or Hess spoon inserted behind the lens and lift the lens out without further pressure from below.

The correctness of this last suggestion became evident one week later when our house surgeon was doing a cataract for me. This patient did not squeeze, but the cystotome did not rupture the anterior capsule and pressure below the cornea caused vitreous to be present at the wound. I at once relieved the doctor of the operation as it was evident that a storm was ahead, and with a wire loop inserted behind the lens, easily extracted it in capsule with no loss of vitreous. This is a procedure we have all used many times and it is dramatically helpful or tragically omitted.

After treatment: If cases 1 and 2 had been dressed in 24 or 48 hours as is customary, I firmly believe a good result would not have followed. The patients were kept as quiet as possible and the eyes not dressed for five days. The Greens do not dress their vacuum cases for ten days, which I have found impracticable. Both eyes were kept covered with dressing and mask for ten days. No medication was used except 1 per cent. noviform ointment and an occasional drop of 1 per cent. atropine and 25 per cent. argyrol.

When the eyes were allowed really to open, the wound in each eye was not fully closed, though firmly healed. There was no prolapse of iris. The scar tissue was increased and the wound closed tightly with daily applications of 1 per cent. silver nitrate and dressing applied to keep the eye closed for several days.

Case 1 was discharged from the hospital in sixteen days; case 2 in twenty-three days. Both cases had a hammock, but not drawn-up pupil. There is no depression of the scar in either case.

In case 3, I expected a collapsed eyeball and so removed the dressing in 24 hours and found the lower part of the eyeball normally rounded and full—the cornea and wound were not inspected—the dressing was reapplied and the eye left alone for four days more. In this case the wound was ragged and irregular but finally closed with silver nitrate and pressure bandage. On the twelfth day and for several days this patient could count fingers, but a few days later could only distinguish light, and I found practically complete detachment of choroid and retina but with a well-rounded eyeball. Doctor Norton Fletcher and

later Doctor Colman W. Cutler saw this patient with me in consultation and both felt that there was no need of removing the eyeball at that time.

Results in Cases 1 and 2

Case 1.—Combined iridectomy and vacuum intracapsular extraction on June 10, 1925. At all times the fundus has been seen easily and the vitreous has been perfectly clear without opacities.

1st Glasses: July 31, 1925.

R + 9.50 + 5.50 ax 35 = 20/40 + 2

3.00 Added for near, gave V = 1.5 D.

This vision gradually improved to 7/26/26:

R + 9.50 + 4.25 ax 25 = 20/15 − 3

+ 3.00 Added for near gave V = 0.75 D.

On May 18, 1926, I did preliminary iridectomy on his other eye and a capsulotomy extraction on June 15, 1926. No vitreous was lost and the best vision obtained was 20/15 = + 9.50 + 3.75 ax 10 and + 3 added for near gave V = 0.75 D.

This patient has a progressing *tabes dorsalis* and is developing optic atrophy with decreasing vision. It is now 20/40 with each eye. Each vitreous is perfectly clear and there are no abnormal fundus changes other than increasing pallor of the discs.

Case 2.—Following preliminary iridectomy I did a vacuum intracapsular extraction on January 26, 1926. The vitreous has shown no opacities and the fundus has remained negative. There has developed marked sclerosing keratitis downward about 3 mm. from the corneo-scleral wound. An unusual apparently non-inflammatory grayish white membrane has gradually developed from above downward over the surface of the vitreous, behind the iris and not attached to it. Fortunately this membrane stopped about 1 mm. above the inferior pupil border and so has not obstructed vision. In fact it has aided vision because it makes a pinhole opening at the lower margin of the pupil.

1st Glasses: 3/4/26/

R + 9.50 + 4 ax 45 = 20/40 + 3

+ 3.00 added for near gave V = 0.75 D.

This vision gradually improved with several changes of glasses. She is now wearing:

R + 12.00 + 1.00 ax 90 and + 3.00 added for near.

When last tested, 2/3/27:
Distance vision = 20/15 + 3 and near vision
= 0.50 D type.

In spring of 1927 she was in an automobile accident without injury to the eye.

In June, 1927, she fell down a flight of stairs head first, and while no bones were broken she was badly bruised and confined to bed for several weeks. I have not taken the vision since then but the family report that it seems to be as good as ever. I saw this patient at home September 23, 1927, and the eye was in perfect condition without vitreous or fundus changes. Her vision was not taken but it appeared to be excellent including reading of fine print.

Case 3 went through the expected course of extreme loss of vitreous and doubtless the eyeball will have to be removed.

Cases 1 and 2 show that marked loss of vitreous does not necessarily mean a lost eye, especially if good coaptation between the cornea and sclera are obtained before the final dressing; and provided the eye is left alone long enough to give a chance for firm closure of the wound and for the eyeball to fill with aqueous.

Cases 1 and 2 have brought to my mind the following argument:

In the presence of marked loss of vitreous, the eye has a greater chance of preservation if the lens has been extracted in capsule than if the posterior capsule was left behind: because, since vitreous is not replaced, the eyeball must be refilled by some fluid to be preserved and that fluid would naturally be the aqueous. If the posterior capsule is intact, its upper edge will quickly heal in the scar and prevent the aqueous from filling the vitreous cavity, and hence allow the eyeball to collapse because of lack of sufficient contents to hold it. Whereas, if the capsule entire has been removed with the lens, the hyaloid having been ruptured, the aqueous has more opportunity to enter the vitreous cavity and so fill the eyeball to its normal capacity. This is what I believe happened in these two cases. This conclusion, however, does not in the least make me anxious to experiment further in the loss of vitreous. I know of nothing in ocular surgery that is more nerve-racking than to see the wound gape and vitreous flow out.

Discussion

Col. Wright (Madras) remarked that apart from vitreous loss during the delivery of the lens one met with cases where the section gaped and the vitreous presented in the wound or actually excaped subsequent to a perfect delivery with reformation of the *fossa patellaris* and falling back of the iris.

In such cases one must consider choroidal hemorrhage or choroidal engorgement as possible causes. In his experience it was difficult to demonstrate such conditions and he had seldom actually proved choroidal detachment ophthalmoscopically. One rather assumed that an increase in volume of the posterior segment after a perfect delivery was of choroidal origin, and that it tended to readjust itself.

Dr. Knapp would like to ask if the loss of vitreous were not due to adhesions between the posterior capsule and the post-lentil space. He does not believe that the aqueous fills the eye replacing the vitreous.

Last February Col. Wright did fifty intracapsular vacuum extractions after the Greens' method. There was no loss of vitreous in those cases.

Section of Ophthalmology, October 17, 1927

A CASE OF CYST OF THE RETINA

Martin Cohen

The history of the patient is as follows:

He was examined three and one-half years ago in school and both eyes were found to be normal. One year later he was examined again in school and the left eye was found to be poorer and he was sent to get glasses. The doctor who examined him at that time gave him glasses with which, he says, vision was good in his left eye and he wore these glasses for school and reading. Last fall he was examined in school and saw only the first three lines on the chart. He then went to an optician who gave him other glasses. He went along without paying attention to his eyes until last fall when school began. He was again examined and his left eye was found to be extremely poor and so, following recommendation of a friend, he came to me.

I found the vision of the right eye to be 20/20 and the left eye, 10/200. The right eye was normal but showed emmetropia. The left eye showed about three diopters of hyperopia. It was externally normal. The vitreous was clear with the exception of a few large floating opacities. The disc was normal. There was a sharply defined, cyst-like detachment in the extreme nasal periphery of the fundus, transparent and at its lower edge showing a crescent-shaped reddish area.

There is visible with a plus 12 to 14 diopters lens, a shiny, glistening, elongated body in the cyst which looks like a light reflex. The retina adjoining the cyst, in the lower periphery of the fundus, is detached. The detachment is shallow and extends from the periphery to the outer three-fourths of the eyeball, and from above extends downward toward the disc in the form of two or three whitish streaks.

These findings were observed on September 20, 1927. One week later he came to the clinic for an examination and the condition was approximately the same. One week later he called again, at which time the detachment had extended so the entire fundus showed a shallow detachment. The appearance of the cyst in the nasal periphery is unchanged. I thought the shiny, elongated body seen in the cyst might be a Cysticercus; it might also be a light reflex which moves as the cystic detachment moves.

Section of Ophthalmology, October 17, 1927

LENTICONUS POSTERIOR

HENRY H. TYSON

A case of Lenti-conus posterior was presented, with two drawings showing the appearance of the same as viewed with the slit lamp, the history of the case being as follows: J. W. T., aged 25 years, male, chauffeur, applied at the Knapp Clinic for glasses to relieve the poor vision in his left eye, which had existed all his life. Vision, R. 20/20; L. 20/200 w-2, 75 20/50. In examining his eye with the ophthalmoscope the oil drop appearance characteristic of the condition was present, associated with a

small opacity in the posterior cortex of the lens running back near the posterior pole, but not reaching it, and with a great difference in the refraction existing between that of the center of the protruding conus and that of the surrounding peripheral lenticular zone, amounting to more than several dioptrics of myopia with a sudden distortion of the images of the margin of the base of the conus which are signs indicative of true lenticonus posterior. The eye backgrounds were normal, while with the slit lamp the picture varied constantly, depending upon the angle and depth of focus used.

The anterior part of the lens was normal, including the embryonal nucleus. The anterior "Y" was readily seen in the normal position, the striae being rather more marked than normal. The posterior "Y" on the other hand was seen only in parts and with great difficulty; whether it was absent or only masked by the white reflex from the opacity lying just behind it could not be positively determined.

The posterior surface of the lens was marked by a saucer-like depression projecting into the vitreous (regarded from the anterior view) approximately circular in outline, but somewhat irregular and wider below than above. It occupied about one-fifth the diameter of the posterior lens surface, and its depth appeared to be about one-third of its diameter, the edge being fairly sharp, but not knife-like. The posterior lens surface immediately surrounding this depression was rather hazy in irregular patches, and within the depression itself the surface showed several round or oval areas of opacity and other areas of roughening, which caused an irregular reflection of the light beam, giving the effect of opacity, though not really opaque. Embryonal hyaloid remains were not recognized, either because absent or obscured and confused by the opaque or hazy areas described. The ring reflex or Vogt, though present was not marked, being in part gray or opalescent, and lacking the fiery brilliance described in other cases. This may be due to the relative shallowness of the conus in this case, with resultant obtuseness of the angle of demarkation. This shallowness may also account for the absence of the horizontal lightband noted in Dr. Marsh's case, when the vertical slit beam crossed the edge of the conus.

A striking feature of the case was an irregular conical opacity in the posterior part of the lens, situated axially between the embryonal nucleus and the normal position of the posterior pole. Broad and flat anteriorly it had an irregular posterior taper to an end like a trumpet mouth, at about the normal curve of the posterior surface. No connection between it and the actual surface could be seen, but possibly some fine threads may extend backward to the surface, concealed on account of the possible angle of observation. Except for its separation from the actual surface, and its irregular form, this opacity resembled one shown and described by Vogt (as figure 234 of his atlas).

In its anatomical characteristics as well as its mathematical ones, the conus in this case seems to occupy a position between Dr. Marsh's case and the one described by Vogt.

Section of Medicine, October 18, 1927

INFRACLAVICULAR TUBERCULOUS INFILTRATIONS

MAURICE FISHBERG

Pulmonary tuberculosis in which the lesion is strictly localized to the apex is very common and, a point which has not been emphasized by clinicians is, that the prognosis in such cases is, as a rule, very good. It seems that apical lesions are usually sclerotic in character, remain dormant, only now and then having exacerbations, but recover quickly. It is very rare that a lesion limited to the apex should spread further down in the lungs and ultimately prove fatal. These patients usually live as long as the average individual, and when death ensues it is most likely due to some non-tuberculous disease.

Recent clinical observation tends to show that in active pulmonary tuberculosis the first or initial lesion appears in most cases in the region of the lung below the clavicle, most commonly in the upper lobe, but at times in the middle or lower lobe, and that these lesions are not of the indurative type just mentioned as characteristic of apical involvement, but of the exudative,

bronchopneumonic and finally caseous type. Physical signs are almost entirely lacking, and in the very beginning the constitutional symptoms may be very mild, hardly inconveniencing the patient for a long time. Only roentgen examination of the chest reveals these lesions, which have been called infraclavicular infiltrations by Assmann, who first described them in 1924.

The onset is usually insidious, the patient losing in weight and strength, coughs, and expectorates blood. In some cases hemoptysis out of a clear sky is the first symptom noted by the patient. A physical exploration of the chest may not reveal any signs of a localized lesion in the lungs, and the patient is told that he suffers from bronchitis, neurasthenia, etc. But in some cases a bacteriological examination of the sputum brings to light tubercle bacilli. A roentgenogram shows that the lesion is not in the apex but below the clavicle. The shadow seen in that region appears as a soft, cloudy, almost homogeneous patch the size of a cherry to that of a pigeon's egg in the midst of healthy lung tissue. The outer margin of the shadow is usually irregular, but now and then it is clear cut and sharply demarkated. These shadows are in many cases located near the periphery of the lung field, but are met with in exceptional cases in any place of the lung.

In a large proportion of cases the disease runs a mild, benign course; the infiltration is absorbed within a few months, hardly leaving anything to indicate its previous location; or linear shadows, characteristic of sclerosis, remain on the roentgenogram. More commonly, in progressive cases, the infiltration undergoes liquefaction and a cavity is formed. Now and then we meet with cases in which the cavity shrinks, at times it may even become completely obliterated. In others the infiltration spreads, involving the greater part of the upper lobe and we then deal with the usual tuberculous lesion seen in progressive cases. These isolated lesions, and isolated cavities, may be found in some cases in the lower lobe of the lung, in others the infiltration is seen to extend like a band across the chest, simulating an interlobar effusion.

Available evidence is in favor of considering these infiltrations as secondary or metastatic deposits of tubercle bacilli from old

dormant lesions acquired during childhood. In some cases the tuberculous infiltration is in itself not as large as it appears on the roentgenogram, but the shadow represents the perifocal or allergie reaction of the lung tissue to the invading infective agent.

These infraclavicular lesions are most commonly found in young persons between 15 and 25 years of age. It seems that they are more apt to occur in individuals who have been excessively exposed to tuberculous infection; who have lived with persons suffering from progressive tuberculosis; or who work with tuberculous material, as physicians, nurses and workers in pathological and bacteriological laboratories. Inasmuch as these seem to be the very earliest lung lesions, we may assume that they are found in this class of persons because these are the very ones that submit to medical, bacteriological and roentgenological examination earlier than others who have had no experience with this disease.

Section of Medicine, October 18, 1927

WORK CAPACITY OF THE TUBERCULOUS*

GRANT THORBURN

After patients who have successfully carried on their curing leave the sanatorium and return to their families and home, they enter one of the most important periods of their cure. Either their disease is healed and they become an asset to themselves, their families and the community, or if a reactivation of their disease takes place, they return to their previous unfortunate status of incapacitation and are a distinct liability.

The group that meets this question at first hand and every day, includes the clinician in private practice who treats tuberculosis, the doctor in tuberculosis clinics, family physicians, and medical officers of industrial houses and corporations, for it is to them that the patient returns following his treatment in an institution.

* This paper will be published in full in the *American Review of Tuberculosis.*

They must advise the man or woman in regard to work, and watch them, and assume the responsibility of their health after the disease has reached a state that permits their leaving the institution.

Their stay in the sanatorium frequently is all too short and they return with their disease only patched up and their confidence impaired.

The advice to get a "light out-door" job is a fallacy, for with such a job it is impossible to earn enough to live in proper hygienic surroundings and obtain proper food. The patient that stays well is the one that realizes his limitations and lives his life accordingly. For patients with means it is a rather easy problem, but for patients without money it is a very difficult problem.

A study was made of 1,000 odd cases of whom 676 were included and careful records kept over a period of three years.

This group of people certainly need attention and realizing this, the New York Tuberculosis and Health Association felt that a study of industry, of available, selected jobs and the effect of vocational and medical supervision was well worthy of study. It was also planned to gain some information in regard to work available for these cases in the city, to watch their physical condition and disease and see if these patients would "stand up" better than those not supervised. We hoped that in this way we could diminish the liability of the patients to relapse, for we believed the percentage of relapses to be high. We also hoped to work out some index or classification of an individual's ability to do selected work, bearing in mind the example of the successful classification of the New York Heart Association.

Under a decreasing donation from the Laura Spellman Fund, a three-year program was worked out, and a highly organized vocational and medical and social service "after care" department was formed, known as the "Vocational Bureau." Careful records of all cases handled in the three years were kept. Complete medical examinations were made and the patients were examined before being sent to a job, while waiting for a position, and after receiving work. To do this, evening clinics were held and painstaking case work, home visiting and social service done on all cases. A complete study of this work will be published this summer.

Certain types of work were ruled out as being not indicated for patients suffering from this disease, such as heavy manual work, dusty trades, grinding, polishing, etc. We found, however, a great many industries in which certain positions were available for these patients, and we attempted to place them in selected jobs as nearly like their former work as possible, and held them under close medical supervision.

We got back about 450 patients of a total of 676 for a final examination over a period of three months to three years, and found that 42½ per cent. remained the same, 33.3 per cent. improved and 24.2 per cent retrogressed or died. Seventeen per cent. had a definite reactivation during the three-year period. We also compared a group of patients that were supervised at the bureau by a group that were not supervised. They were unselected as to stage and condition of disease except that no active cases were included.

We found that the supervised patients showed 35 more cases with the disease better, than those not supervised. We also found that many of these patients had complications in addition to their pulmonary tuberculosis. One hundred and eighty-one patients had one complication, 189 had two, 161 had three, and 59 had four or more, in addition to their disease.

A work classification was also prepared for the potential employee with tuberculosis. Three subdivisions were made in which it was shown whether the patient was considered feasible for full-time work, standing or sedentary, and finally, part-time.

We feel that this problem of after care is one of the most urgent questions to face in our efforts to get the better of tuberculosis. It is of little avail to build institutions, increase beds and segregate the tuberculous for treatment, taking them away from their homes and families, if you have no further final constructive routine for them to follow when the progress of their disease is halted and their symptoms cleared up.

Section of Orthopedic Surgery, October 21, 1927

THE PATHOLOGY AND PATHOGENESIS OF PERTHES' DISEASE

A. PHILIP ZEMANSKY, JR.

Lantern slides were exhibited illustrating the pathological picture of the head of the femur in a case of Perthes' disease. The findings were:

1. Extensive subchondral necrosis of bone and marrow.
2. Practically complete destruction of the epiphyseal line.
3. Fragments of dead bone surrounded by granulation tissue containing many multinucleated giant cells.
4. Fibrous tissue replacement of necrotic areas.
5. Osteoid tissue growing into fibrous tissue from cartilage above and from bone below.
6. Minute hemorrhages in the under surface of the cartilage.

From a review of the reported cases where the head of the femur had been examined pathologically the question of etiology and pathogenesis were discussed. The two most likely theories, infection and vascular occlusion were compared and the former eliminated from lack of pathological evidence in favor of bacterial invasion. The latter theory, on the basis of trauma to the blood vessels of the epiphysis, was held to be the most likely one, from the fact that the lesion closely resembled an infarct and that there was evidence of damage to those structures which carry the vessels supplying the epiphysis. The age distribution of the disease was explained on this basis, since before complete ossification the head receives no blood supply from the neck or shaft. Experimental results of Müller were cited to support this contention. Healing by formation of new bone was shown to be incomplete even after several years, and doubt was expressed as to the amount of spontaneous healing by new bone formation that can be expected in this disease, within a reasonable time.

Section of Obstetrics and Gynecology, October 25, 1927

INFECTED MYOMA UTERI; WITH REMARKS ON RED DEGENERATION

MEYER M. STARK

By red degeneration we mean a form of necrosis or necrobiosis, appearing in myoma uteri, the red or other discoloration resulting from the diffusion through the specimen of the blood pigments, following hemolysis from excess of lipoids present. A continued excess of these lipoids will give other hues, ranging from mahogany to yellow, and finally to grey. Thus, on section, is offered a macroscopic difference from the accustomed white and shiny appearance of the unaltered fibroids. This necrosis is an aseptic process, bacteria being evident only in the infected cases. Infection is secondary to the degeneration. It is not conceivable that the hemolytic bacteria, ordinarily present in the vagina or cervix, are responsible for the suppurations found.

The change usually affects only one tumor, if others are present, and the mass increases in size suddenly upon the advent of the necrosis, the color differs with the amount of haemolyzing agent present and duration of its activity, but is most frequently pink or reddish, and is not followed by severe invalidism. Infection, however, is serious, setting up a marked toxic phase, with high temperature and leucocytosis and is considered fatal unless operated upon.

Degeneration is not infrequent, occurring as often as five to seven times every 100 cases, and is much more frequent in pregnancy; operation is never urgent and sometimes unnecessary, and in pregnant cases is elective at or after full term, and not usually urgent in the course of the gestation. On the other hand, suppuration is rare. Bacteria present are coli, staphylococci and streptococci, but gonococci have not been reported.

Symptoms are pain, tenderness, increase in size of tumor. An acute onset, with peritoneal irritation, high temperature, nausea and vomiting, and a decided toxic phase accompanies the suppurating types.

Summary.—Degeneration of fibroids is associated with the presence of lipoids, the accumulation of which is dependent on the presence and extent of thrombosis or infection. Infection is never primary. Thrombosis is not thought to be primary and not always present; in infection, it is likely primary. The microscopy is characterized by hyaline and granular degeneration, replacing or separating the muscle fibers remaining by the presence of fat and of karyolysis, the fat probably resulting from muscle change. There is no round-cell infiltration. Pregnancy is a predisposing factor. Infection gives rise to toxemia and is fatal, unless operation is undertaken, and here the mortality is high; in simple degeneration, operation is ofttimes advisable and can be successfully performed.

Section of Obstetrics and Gynecology, October 25, 1927

ACTINOMYCOSIS OF THE OVARY AND FALLOPIAN TUBE

Report of Case with Pathologic Examination

ARTHUR STEIN

Actinomycosis involving the ovary, Fallopian tube or parametrium is an extremely rare condition, a survey of the literature yielding only forty-three cases to date. How the infection reaches the ovary in cases of ovarian actinomycosis, is a moot point. It was formerly believed that the ray fungus may enter the vagina and reach the ovary directly through the genital passages. A more likely theory is that the disease is secondary to intestinal actinomycosis. Actinomycosis has a predilection for the intestinal tract, and the lesion shows a tendency to burrow through the walls of the gut. The cecum and appendix constitute the favorite site for intestinal lesions, and it is easy to understand how the right ovary may become involved by a burrowing infection in this location. In the entire series of forty-three cases, the actinomycotic lesions in the genital tract were

located as follows: Ovaries alone, 17; tubes alone, 5; parametrium, 7; ovaries and tubes, 7; various combinations of ovaries, tubes, parametrium and uterus, 7.

The diagnosis of ovarian actinomycosis cannot be made until laparotomy is performed. Even then it may be in doubt unless the characteristic sulphur granules are in evidence, although a large, worm-eaten ovarian tumor filled with multiple tiny abscesses is very suggestive. The gross appearance of the organs often suggests a neoplasm, until the pathologist's report establishes the true condition.

The prognosis, according to published reports, is bad. In thirty-seven cases in which sufficient data were given, twenty-seven patients died, nine were considered as improved when last observed, and only one was designated as apparently recovered.

Treatment is extremely unsatisfactory, especially in view of the fact that the diagnosis is seldom made before the lesion is far advanced. Where involvement is not too extensive, an attempt should be made to eradicate all of the diseased tissue. By way of medication, potassium iodide in large dosage is probably the only remedy that has been found of definite service; but many cases of abdominal actinomycosis fail to show benefit from its use.

A case of actinomycosis of the right ovary and Fallopian tube, with chronic salpingitis and peri-oöphoritis on the opposite side, is reported. The patient was a housewife, aged 39, whose only symptoms were pain in the right inguinal region and persistent fever. The uterus was enlarged, and there was a mass the size of an orange occupying the position of the right adnexa. The clinical diagnosis was right pyo-salpinx, and at laparotomy a pseudo-tumor composed of the right pyo-salpinx, the uterus, omentum and coils of intestines, all bound together by adhesions, was found. There was nothing to suggest the rare condition of pelvic actinomycosis. A persistent, discharging fistula remained after the operation, and later the right inguinal glands broke down. A second laparotomy was performed but the patient died. Microscopic sections from the remains of the right ovarian tumor mass showed typical colonies of *Actinomycetes bovis*.

PROCEEDINGS OF ACADEMY MEETINGS, OCTOBER, 1927

Stated Meetings

Thursday Evening, October 6, at 8:30 o'clock

ORDER

I. Executive Session.
   Election of Fellows.
   Election of a Trustee.
   Action on amendments to Constitution and By-laws.

II. Papers of the Evening.
   a. The prevalence of disease, Edgar Sydenstricker, Statistician, U. S. Public Health Service, Washington (by invitation).
   b. The cost of medical service, Louis I. Dublin, Statistician, Metropolitan Life Insurance Company (by invitation).
   c. A campaign for health and safety in industry. Illustrated by motion pictures, Leland E. Cofer, Director, Bureau of Industrial Hygiene, State of New York.

Thursday Evening, October 20, at 8:30 o'clock

ORDER

I. Executive Session.

II. The Wesley M. Carpenter Lecture.
   The future food supply of the United States, Alonzo E. Taylor, Director of Food Research, Stanford University (by invitation).

Section Meetings

Section of Dermatology and Syphilis

Tuesday Evening, October 4, at 8:00 o clock

ORDER

I. Presentation of Patients.
   a. Cases from the New York Skin and Cancer Hospital, service of J. Francis Aitken.

1. Presented by Paul E. Bechet.
2. Presented by Binford Throne, service of A. Schuyler Clark and Binford Throne.

b. Cases from the Mt. Sinai Hospital.

c. Miscellaneous cases.

II. Discussion.

III. Executive Session.

Section of Surgery

Friday Evening, October 7, at 8:30 o'clock

ORDER

I. Reading of the Minutes.

II. Presentation of Cases.

a. Suppurative appendicitis—paralytic ileus, enterostomy—recovery, Philip J. Lipsett.

b. Repair strangulated incisional hernia one year after simple drainage for appendix abscess, appendectomy, Frank B. Berry.

c. Acute suppurative pleurisy with secondary pneumococcus peritonitis, Paul A. Dineen.

d. Cases illustrating first paper of the evening, Condict W. Cutler, Jr.

III. Papers of the Evening.

1. Post-operative complications of suppurative appendicitis, Condict W. Cutler, Jr.
2. Preliminary medication and general anesthesia with special reference to the margin of safety in post-operative lung lesions (lantern slides and photomicrographs), Charles W. Hooper (by invitation), James T. Gwathmey.

IV. General Discussion.

Section of Neurology and Psychiatry

Tuesday Evening, October 11, at 8:30 o'clock

ORDER

I. Reading of the Minutes.

II. In Memoriam: Thomas William Salmon, Frankwood E. Williams.

III. Case Presentation.

Profound emaciation of unknown origin, John McD. McKinney.

IV. Papers of the Evening.

a. Experiences with encephalography *via* lumbar route, E. D. Friedman.

Discussion, Temple Fay (by invitation), Charles A. Elsberg, Foster Kennedy, Israel Strauss.

b. A visit to the Spanish school of neuro-histology, Lewis D. Stevenson.

Discussion, Lawrence S. Kubie (by invitation), Wilder G. Penfield.

V. Executive Session.

Section of Otology

Friday Evening, October 14, at 8:30 o'clock

Introductory meeting to "Better Hearing Week" held in conjunction with the New York League for the Hard of Hearing.

ORDER

I. Reading of the Minutes.

II. Addresses.

a. Hearing, Louis I. Harris, Commissioner of Health.

b. The importance of public opinion regarding the hearing problem, Mrs. William Brown Maloney, Editor, Magazine Section, New York Herald-Tribune (by invitation).

c. Fads and Fakes in deafness cures, Arthur J. Cramp, Director, Bureau of Investigation, American Medical Association (by invitation).

d. The lay press cooperation in public health education, Mr. William H. Neel, Advertising Censor, The New York Times (by invitation).

Section of Ophthalmology

Monday Evening, October 17, at 8:30 o'clock

ORDER

I. Reading of the Minutes.

II. Presentation of Cases.
   a. Lenticonus posterior, Henry H. Tyson.
   b. Lantern slide demonstration of microscopic preparations of contusions of the globe, Algernon B. Reese (by invitation).
III. Paper of the Evening.
   Loss of vitreous, Isaac Hartshorne.
IV. General Discussion.
V. Executive Session.

Section of Medicine

Tuesday Evening, October 18, at 8:30 o'clock

ORDER

I. Reading of the Minutes.
II. Papers of the Evening.
   a. Infraclavicular tuberculous infiltrations, Maurice Fishberg.
   b. Work capacity of the tuberculous, Grant Thorburn.
III. Discussion, Henry T. Chickering, Emanuel Libman, James Alexander Miller.

Section of Genito-Urinary Surgery

Wednesday Evening, October 19, at 8:30 o'clock

Program furnished by the Department of Urology, Yale University School of Medicine

ORDER

I. Reading of the Minutes.
II. Presentation of Cases.
   Prostatic cyst with congenital absence of right kidney, Frederick Roberts, New Haven (by invitation).
III. Papers of the Evening.
   a. Tissue culture from interstitial cystitis, Charles Y. Bidgood, New Haven (by invitation).
   b. Iodized oil as a pyelographic median, C. H. Newswanger, New Haven (by invitation).
   c. Renal circulation following various types of nephrotomies, Clyde Leroy Deming, New Haven (by invitation).

IV. General Discussion.
V. Executive Session.

Section of Orthopedic Surgery

Friday Evening, October 21, at 8:30 o'clock

ORDER

I. Reading of the Minutes.
II. Papers of the Evening.
  a. Head-tilting and head-turning of ocular origin. Lantern slides. James Watson White.
  b. Remarks on Legg-Perthes disease, with report of an operated case, Royal Whitman.
  c. The pathology and pathogenesis of Legg-Perthes disease. Lantern slides. A. Philip Zemansky, Jr. (by invitation).

Section of Obstetrics and Gynecology

Tuesday Evening, October 25, at 8:30 o'clock

ORDER

I. Reading of the Minutes.
II. Presentation of Cases.
  A case of infected myoma uteri showing red degeneration (with lantern slides), Meyer M. Stark.
III. Papers of the Evening.
  a. Actinomycosis of the ovary, Arthur Stein.
  b. Difference between Hegar's and Ladin's sign of early pregnancy (with lantern slides), David W. Tovey.
IV. General Discussion.
V. Executive Session.

Section of Neurology and Psychiatry

(Special Meeting)

Tuesday Evening, October 25, at 9:00 o'clock

Address:
  "Some laboratory observations upon reflex action," Sir Charles Scott Sherrington, M.D., F.R.S., Oxford.

RESPONSE:

Samuel W. Lambert, President, The New York Academy of Medicine.

SECTION OF LARYNGOLOGY AND RHINOLOGY

Wednesday Evening, October 26, at 8:30 o'clock

ORDER

I. READING OF THE MINUTES.

II. PAPER OF THE EVENING.

The treatment of malignant disease of the larynx by means of diathermy, Professor E. Schmiegelow, Copenhagen (by invitation).

Discussion opened by Chas. J. Imperatori, John E. MacKenty, John McCoy, George A. Wyeth, Sidney Yankauer.

Preceding the meeting, the section will entertain Professor Schmiegelow at dinner.

COMBINED MEETING OF THE NEW ENGLAND PEDIATRIC SOCIETY, PHILADELPHIA PEDIATRIC SOCIETY, AND SECTION OF PEDIATRICS OF THE NEW YORK ACADEMY OF MEDICINE

Saturday, October 29

PROGRAM

9:30 a. m. Bellevue Hospital. Ward G6. Introductory remarks, Charles Hendee Smith.

Factors influencing the calcium level in the blood-serum of infants with tetany, Harry Bakwin.

Further observations, Charles R. Stockard.

Chronic nephritis in children, John D. Lyttle.

10:30 a. m. Inspection of the new pediatric pavilion.

11:30 a. m. Hospital of the Rockefeller Institute. Gasometric micromethods for clinical analysis, D. D. Van Slyke (by invitation).

Etiology, pathology and prevention of measles, T. M. Rivers (by invitation).

Cinematographic studies of normal and malignant cells, Alexis Carrel (by invitation), A. H. Ebeling (by invitation).

1:15 p. m. Luncheon at the Rockefeller Institute.

2:30 p. m. The New York Academy of Medicine. Healing in scurvy as shown by x-ray, Stafford McLean, Rustin McIntosh.

The anatomic lesion of so-called pyelitis in infancy, James R. Wilson (by invitation), Oscar M. Schloss.

Certain aspects of tuberculosis in infancy, Bela Schick.

Seasonal variation of growth in children, Haven Emerson.

4:30 p. m. Inspection of the Academy Building.

SECTION OF HISTORICAL AND CULTURAL MEDICINE

Monday Evening, October 31, at 8:30 o'clock

ORDER

I. READING OF THE MINUTES.

II. PAPERS OF THE EVENING.

a. Early medical Americana, with demonstrations by lantern slides and books, Archibald Malloch (by invitation).

b. Colonial medicine, Thomas J. Harris.

c. Discussion as to the scope of the activities of this section.

NOVEMBER, 1927

STATED MEETINGS

Thursday Evening, November 3, at 8:30 o'clock

ORDER

I. Executive session.

a. Report of the Nominating Committee. Nominations for one Vice-President for three years; Recording Secretary for three years; two Trustees for five years; three members of the Committee on Admission for three years and one for two years; one member of the Library Committee for five years.

b. Election of Fellows.

II. Paper of the evening.
Recent knowledge of epidemic diseases, Leslie T. Webster, Rockefeller Institute for Medical Research (by invitation).

Thursday evening, November 17, at 8:30 o'clock

ORDER

I. Executive session.
II. The anniversary discourse.
"Mind and Body," John Dewey, Professor of Philosophy, Columbia University.

Section Meetings

Section of Dermatology and Syphilis

Tuesday evening, November 1, at 8:00 o'clock

ORDER

I. Presentation of patients.
a. Cases from the Vanderbilt Clinic, J. Gardner Hopkins, A. Benson Cannon, George C. Andrews, L. W. McCafferty.
b. Miscellaneous cases.
c. Skin and Cancer Hospital. Examination of clinical cutaneous lesions under filtered ultra-violet, Herman Goodman.
II. Discussion.
III. Executive session.

Note: Examination of cases is limited to members and their invited guests.

Section of Neurology and Psychiatry

Combined meeting with the New York Neurological Society

*Tuesday evening, November 1, at 8:30 o'clock

ORDER

I. Reading of the minutes.
II. Clinical and Pathological presentation (lantern slides).
Aneurysm of the cerebral vessels, Irving J. Sands.
III. Papers of the evening.

* Please note change in date.

a. Cerebral pneumography. Its use and abuse, Wilder G. Penfield.

b. The classification of extra-dural spinal tumors with remarks on the origin of the so-called endotheliomas, Charles A. Elsberg.

c. The modern treatment of trigeminal neuralgia with case presentations, Byron P. Stookey.

IV. Executive session.

Section of Surgery

Friday evening, November 4, at 8:30 o'clock

ORDER

I. Reading of the minutes.

II. Presentation of cases.

a. 1. Traumatic rupture of spleen; splenectomy; autotransfusion.

2. Spindle-cell sarcoma of soft parts of calf; amputation; well five and a half years later.

3. Strangulated femoral hernia; enterostomy; later enteroanastomosis with Murphy button, Bradley L. Coley.

b. Fracture of both bones of leg (2 cases), William F. MacFee.

c. Cases illustrating the first paper of the evening, John H. Garlock.

III. Papers of the evening.

a. The treatment of compound injuries of the extremities, John H. Garlock.

b. Cervical and lumbar ganglionestomy in painful conditions of the extremities. Preliminary report, William F. Honan.

Section of Pediatrics

Thursday evening, November 10, at 8:30 o'clock

ORDER

I. Reading of the minutes.

II. Papers of the evening.

a. Neuroblastoma of the adrenal in young children, Martha Wollstein.

b. The earlier diagnosis of measles, Philip M. Stimson.
Discussed by Oscar M. Schloss, Shirley W. Wynne.

c. Some of the common dermatological conditions observed in infancy and childhood, A. Benson Cannon.
Discussed by J. Gardner Hopkins.

Section of Otology

Friday evening, November 11, at 8:30 o'clock

ORDER

I. Reading of the minutes.

II. Address: New histopathological findings in the ear in lues. The importance of the general pathology of the ear (illustrated by lantern slides), Professor Gustav Alexander, Vienna (by invitation).
Discussion, Edward B. Dench.

III. Executive session.

Section of Medicine

Tuesday evening, November 15, at 8:30 o'clock

ORDER

I. Papers of the evening.

a. Relation of high blood pressure to blood sugar, Herman Mosenthal.

b. The high-carbohydrate low-fat diet in the treatment of diabetes with and without insulin, H. Rawle Geyelin (by invitation).

c. Experiences with oral substitutes for insulin in the treatment of diabetes, A. I. Ringer, S. Biloon (by invitation), M. M. Harris (by invitation), A. Landy (by invitation).

II. Discussion by Eugene F. DuBois, E. Brand (by invitation).

Section of Genito-urinary Surgery

Wednesday evening, November 16, at 8:30 o'clock

ORDER

I. Reading of the minutes.

II. Presentation of instruments.
A modification of the McCarthy cystourethroscope for inspection, diagnosis and treatment with electrical, surgical and non-operative methods, with lantern slide demonstration, Victor C. Pedersen.

III. Papers of the evening.
A Symposium on Gonorrhea.
a. The present day treatment of acute gonorrhea in the male, Abram L. Wolbarst (by invitation).
b. The present day treatment of chronic gonnorrhea in the male, Joseph A. Hyams.
c. The rôle of the gonococcus in sterility, Max Hühner.
d. The surgical complications of gonorrhea, Howard S. Jeck.
e. The joint and cardiac complications of gonorrhea, John H. Morrissey.
f. The use of diathermy in acute and chronic gonorrhea, Leo L. Michel.
g. Gonorrhea in the female, Horace E. Ayres (by invitation).

IV. Discussion opened by Boleslaw Lapowski, Solomon Wiener.

V. Executive session.

Section of Orthopedic Surgery

Friday evening, November 18, at 8:30 o'clock

ORDER

I. Reading of the minutes.

II. Presentation of cases illustrating the Orr method of treatment, Leo Mayer, Elmer P. Weigel, Samuel Kleinberg.

III. Paper of the evening.
Asepsis and rest versus antisepsis in the treatment of infected fractures and joint injuries (lantern slides), H. Winnett Orr (by invitation).

IV. Discussion to be opened by Frederic W. Bancroft, Walton Martin, Walter M. Brickner, Fred H. Albee, Leo Mayer, Samuel Kleinberg, Armitage Whitman, Elmer P. Weigel.

V. General discussion.

Section of Ophthalmology

Monday evening, November 21, at 8:30 o'clock

ORDER

I. Reading of the minutes.
II. Presentation of cases.
   a. A case of traumatic ocular muscle paralysis with retraction, Arnold Knapp.
   b. Demonstration of gross and microscopic eye preparations, with suggestions for the successful preparation of eye specimens both gross and microscopic, Louise H. Meeker (by invitation).
III. Paper of the evening.
   Training of the blind in Germany, Betty Hirsch (by invitation).
IV. Discussion by Ellice M. Alger, Edward Van Cleve (by invitation).
V. Executive session.

Section of Obstetrics and Gynecology

Tuesday evening, November 22, at 8:30 o'clock

ORDER

I. Reading of the minutes.
II. Presentation of cases.
   a. Intraligamentous pregnancy, full term (with lantern slides), M. O. Magid.
   b. Intermedullary focal necrosis of the left frontal lobe, probably of hemorrhagic origin intercurrent in puerperal eclampsia, Joseph Binder (by invitation).
III. Paper of the evening.
   Recent advances in obstetric technic (with lantern slides and motion pictures), Paul Titus, Pittsburgh (by invitation).
   Discussion by George W. Kosmak, John O. Polak, George H. Ryder.
IV. General discussion.
V. Executive session.

Section of Laryngology and Rhinology

Wednesday evening, November 23, at 8:30 o'clock

ORDER

I. Reading of the minutes.
II. Paper of the evening.
The location of the focus in optic nerve disturbances from infection, Leon E. White, Boston (by invitation).
Discussion opened by Colman W. Cutler, John E. Weeks, John M. Wheeler, Lewis A. Coffin, H. Beaman Douglass, E. Ross Faulkner.

Section of Historical and Cultural Medicine

Wednesday evening, November 30, at 8:30 o'clock

ORDER

Symposium in memory of Lister.
I. Papers of the evening.
a. Biographical sketch and memorabilia of Lister, Archibald Malloch (by invitation).
b. An account of Lister's surgical work, George David Stewart.
c. An account of Lister's physiological work, John Tait, Professor of Physiology, McGill University, Montreal (by invitation).
d. Lister in relation to the Victorian background, Fielding H. Garrison, Washington (by invitation).

PRACTICAL LECTURES

The New York Academy of Medicine announces a second series of lectures for the general practitioner to be held on Friday afternoons at 4 o'clock. The profession generally is invited to attend.

1927

Nov. 4—Certain conditions in the diagnostic borderland between medicine and surgery: Carl A. Hamann, Professor of Applied Anatomy and Clinical Surgery, Western Reserve University, Cleveland.

Nov. 11—Diagnosis of diseases of the gall-bladder: Allen O. Whipple, Professor of Surgery, Columbia University, N. Y.

Nov. 18—Certain fractures and their management: John J. Moorhead, Post-Graduate Medical School and Hospital, N. Y.

Nov. 25—Postabortal and puerperal infections: B. P. Watson, Professor of Obstetrics and Gynecology, Columbia University, N. Y.

Dec. 2—Bronchoscopy, lung abscess from foreign bodies: Chevalier Jackson, Professor of Bronchoscopy and Esophagoscopy, University of Pennsylvania, Philadelphia.

Dec. 9—Acute disease of the accessory sinuses and its treatment: Thomas J. Harris, Post-Graduate Medical School and Hospital, N. Y.

Dec. 16—Present day treatment of gonorrhea in the male: Howard S. Jeck, Bellevue Hospital, N. Y.

Dec. 23—The responsibility of the doctor in the development of teeth and dental infections: William H. Haskin, Manhattan Eye, Ear, Nose and Throat Hospital, N. Y.

1928

Jan. 6—Early diagnosis of pulmonary tuberculosis for the general practitioner: Lawrason Brown, Saranac Lake, N. Y.

Jan. 13—Diphtheria, measles and scarlet fever control: William H. Park, Director of Laboratories, Department of Health, N. Y.

Jan. 20—The endocrine disturbances of childhood. Lantern demonstrations: Fritz Bradley Talbot, Professor of Pediatrics, Harvard Medical School, Boston.

Jan. 27—The diagnostic and therapeutic significance of the inorganic constituents of the blood: J. Harold Austin, Professor of Research Medicine, University of Pennsylvania, Philadelphia.

Feb. 3—Modern physiotherapy in medical practice: Harry Eaton Stewart, Director of School of Physical Therapy, New Haven.

Feb. 10—Radium in the treatment of cancer: Douglas Quick, Memorial Hospital, N. Y.

Feb. 17—A discussion of the developmental abnormalities about the lumbosacral juncture as the cause of backache: Russell

A. Hibbs, Professor of Orthopedic Surgery, Columbia University, N. Y.

Feb. 24—Bone tumors: James Ewing, Professor of Pathology, Cornell University, N. Y.

Mar. 2—The treatment of hypertension: Herman O. Mosenthal, Post-Graduate Medical School and Hospital, N. Y.

Mar. 9—Obesity: Pathology and treatment: Solomon Strouse, Associate Professor of Internal Medicine, Northwestern University, Chicago.

Mar. 16—Skin diseases due to animal parasites. Lantern demonstrations: Howard Fox, Professor of Dermatology and Syphilology, New York University, N. Y.

Mar. 23—Deafness and its prevention: Arthur B. Duel, Manhattan Eye, Ear and Throat Hospital, N. Y.

Mar. 30—The eye-ground in general diagnosis. A lantern talk: William Evans Bruner, Professor of Ophthalmology, Western Reserve University, Cleveland.

Apr. 13—Practical suggestions in the treatment of certain habit problems of children: Lawson G. Lowrey, Director, Institute for Child Guidance, N. Y.

Apr. 20—The treatment of asthma: William S. Thomas, St. Luke's Hospital, N. Y.

Apr. 27—The diagnosis of rectal diseases: Jerome M. Lynch, Polyclinic Medical School and Hospital, N. Y.

RECENT ACCESSIONS

Bauer, J. Innere Sekretion.
Berlin, Springer, 1927, 479 p.

Bayly, H. W. Venereal disease. 3. ed.
London, Faber, 1927, 242 p.

Behrend, M. Surgical diseases of the gall-bladder, liver and pancreas.
Philadelphia, Davis, 1927, 278 p.

Brouwer, B. Anatomical, phylogenetical and clinical studies on the central nervous system.
Baltimore, J. H. Univ., 1927, 67 p.

Bruce, H. A. Your growing child.
New York, Funk, 1927, 405 p.

Cooper, E. A., & Nicholas, S. D. Aids to biochemistry.
London, Baillière, 1927, 188 p.

Crohn, B. B. Affections of the stomach.
Philadelphia, Saunders, 1927, 902 p.

Douthwaite, A. H. The injection treatment of varicose veins.
London, Lewis, 1927, 39 p.

Drueck, C. J. Fistula of the anus and rectum.
Philadelphia, Davis, 1927, 318 p.

Dumsday, W. H. Milk and dairies handbook.
London, Hadden, 1927, 264 p.

Einhorn, M. Le tube duodénal.
Paris, Masson, 1927, 136 p.

Emmel, V. E. The B N A arranged as an outline of regional and systematic anatomy. 2. ed.
Philadelphia, Wistar inst., 1927, 256 p.

Félix Lagrange et ses élèves. (Pages choisies.)
Paris, Doin, 1927, 698 p.

Fischer, I. Die Gynäkologie bei Dioskurides und Plinius.
Wien, Springer, 1927, 36 p.

Handbuch der mikroskopischen Anatomie des Menschen. Hrsg. von. W. Mollendorf. Vol. 3. Haut und Sinnesorgane. Vol. 5, pt. I. Verdauungsapparat.
Berlin, Springer, 1927.

Hare, H. A. A text-book of practical therapeutics. 20. ed.
Philadelphia, Lea, 1927, 1094 p.

Hesnard, A. Les syndromes névropathiques.
Paris, Doin, 1927, 247 p.

Joseph, Baron Lister. Centenary volume 1827–1927. Edited . . . by A. Logan Turner.
Edinburgh, Oliver, 1927, 182 p.

Keiller, W. Nerve tracts of the brain and cord.
New York, Macmillan, 1927, 456 p.

Lane, Sir W. A. Secrets of good health.
London, Heinemann, 1927, 152 p.

Lapicque, L. L'excitabilité en fonction du temps, la chronaxie.
Paris, Pr. univ. d. France, 1926, 370 p.

Lewis, F. T., & Bremer, J. L. A text-book of histology.
Philadelphia, Blakiston, 1927, 551 p.

Lewis, T. The blood vessels of the human skin and their responses.
London, Shaw, 1927, 322 p.

Macfarlane, C. A reference hand-book of gynecology for nurses. 5. ed.
Philadelphia, Saunders, 1927, 170 p.

MacKee, G. M. X-rays and radium in the treatment of diseases of the skin. 2. ed.
Philadelphia, Lea, 1927, 788 p.

Malingwski, B. Sex and repression in savage society.
London, Kegan Paul, 1927, 285 p.

Manual of psychiatry. Ed. by A. J. Rosanoff. 6. ed.
New York, Wiley, 1927, 697 p.

McNeil, A. S. The cancer mystery solved.
London, Daniel co., 1927, 96 p.

Morrow, C. A. Biochemical laboratory methods.
New York, Wiley, 1927, 350 p.

Morse, W. Applied biochemistry. 2. ed. . . .
Philadelphia, Saunders, 1927, 988 p.

Muller, J. P. My sun-bathing and fresh-air system.
London, Athletic pub., 1927, 126 p.

Nicholson, W. Smoke abatement. 2. ed.
London, Griffin, 1927, 194 p.

Pearl, R. To begin with.
New York, Knopf, 1927, 96 p.

Penman, D., & Penman, J. S. The principles and practice of mine ventilation.
London, Griffin, 1927, 303 p.

Peter, L. C. The extra-ocular muscles.
Philadelphia, Lea, 1927, 294 p.

Poffenberger, A. T. Applied psychology.
New York, Appleton, 1927, 586 p.

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FELLOWS ELECTED NOVEMBER 3, 1927

David Beck, M.D., 145 West 86th Street.
David Bloom, M.D., 135 East 50th Street.
Van Alstyne Cornell, M.D., 110 West 55th Street.
Millicent Mary Augusta Cosgrave, M.D., 52 East 78th Street.
James Joseph Duffy, M.D., 350 Park Avenue.
Genovese Serafino, M.D., 260 Fifth Avenue, L. I. City.
Leopold Israel Glushak, M.D., 317 West 89th Street.
Richard Emanuel Gordon, M.D., 106 Central Park West.
Max Greenwald, M.D., 38 West 59th Street.
Ralph Eugene Herendeen, M.D., 30 East 40th Street.
Henry Keller, M.D., 498 West End Avenue.
Julius Kurzrock, M.D., 178 East 111th Street.
Nathan Magida, M.D., 514 West End Avenue.
Eric Milton Matsner, M.D., 36 West 89th Street.
John Neilson, Jr., 121 East 60th Street.
Mortimer William Rodgers, M.D., 55 East 86th Street.
Harry Clayton Saunders, M.D., 161 West 87th Street.
Melchior Francis Rosary Savarese, M.D., 209 Washington Park, Brooklyn.

Harry Paul Swift, M.D., 260 West 76th Street.
Louis Tulipan, M.D., 224 East 17th Street.
James Flandreau Van Fleet, M.D., 17 East 38th Street.

And for Associate Fellowship:

Isaac Neuwirth, B.S., 2144 Crotona Parkway.

RESOLUTION OF THE COUNCIL: DR. HERBERT S. CARTER

Resolved, That the Council of The New York Academy of Medicine hereby records its sense of deep loss in the death of Dr. Herbert S. Carter, a Fellow of this Academy.

Dr. Carter was elected a Fellow in 1905 and always had an active interest in its affairs. He was Chairman of the Section on Medicine in 1908, and a member of the Library Committee from 1920 to 1923. He was a member of the Committee on Revision of By-Laws in 1924, and was elected Vice-President of the Academy, serving for a period of three years, ending in 1926.

Dr. Carter was characterized by his unfailing patience, courtesy, gentleness and devotion to his practice. During a period of thirty-five years in the practice of medicine he displayed unfailing interest in the practice of his profession, particularly in his own chosen field. He was devoted to his patients and their welfare, and in the midst of a busy practice, while frequently affected by ill health, gave unsparingly of his time to many other useful fields of human endeavor.

Resolved, That a copy of this resolution be sent to the members of his family and be spread upon the minutes of this body.

OBITUARIES

DR. HERBERT SWIFT CARTER

Dr. Herbert Swift Carter graduated from Princeton in 1892 (B.A.) and from the College of Physicians and Surgeons of New York in 1895. He then served on the house-staff of the Presbyterian Hospital of this city and, after subsequent study in Berlin and other European centers, returned to New York to engage in the practise of medicine. He soon became a member of the Medical Boards of the Lincoln and other hospitals from which, after a number of years he withdrew to specialize in gastro-

enterology. It was rather a remarkable coincidence that for many years he had suffered from gastro-duodenal ulceration, one of the more frequent lesions he was called upon to treat, and which ultimately led to his death. About ten years ago he was appointed consulting-gastroenterologist to the Presbyterian Hospital, a position which he occupied at the time of his death.

Dr. Carter was a member of various social and professional organizations to none of which he was more loyal than to the Academy of Medicine. He was elected a Fellow of the Academy in 1905 and always took an active interest in its affairs. He was Chairman of the Section of Medicine in 1908, and a member of the Library Committee from 1920 to 1923. He was elected Vice-President of the Academy in 1923, in which capacity he served for three years; and was a member of the Committee on Revision of By-laws in 1924. He not only devoted much time and attention to these various executive duties, but contributed most generously as well to the needs of the Academy some fifteen years ago when its quarters were becoming cramped and inadequate.

In his under-graduate days, as an interne in the hospital, and in his subsequent private and hospital practise, Dr. Carter combined great professional skill with a most attractive personality. Quiet, unassuming and modest, he never made the slightest effort to advance his personal interests. On the contrary he was inclined to favor the choice of some less able professional rival to fill a vacant position on some hospital staff. To his patients Dr. Carter was most devoted. Rich and poor alike received equal attention and consideration, and to the latter he was frequently more than a physician in giving freely encouragement and advice. It will never be known how often he relieved in a substantial way the needs of those whose earning capacity had either been interrupted or destroyed.

It is difficult to give an accurate estimate of Dr. Carter's contribution to medicine. His medical skill, his culture and refinement, and above all his social charm, unquestionably served to place the medical profession on a higher plane. Fortunate indeed was that profession to have attracted to its ranks one who served it to such good purpose, and who would have equally graced any other profession that he might have chosen. The

influence for good that he exerted was felt by all his associates. It stimulated his juniors and those of his own circle to strive to develop the same nobility of character. It was not without effect on his seniors, and every one within his circle was the better for the contact. While his loss will continue to be most keenly felt by a host of friends and while his place can never be adequately filled, the influence of his example will go marching on to benefit many who will follow in his footsteps.

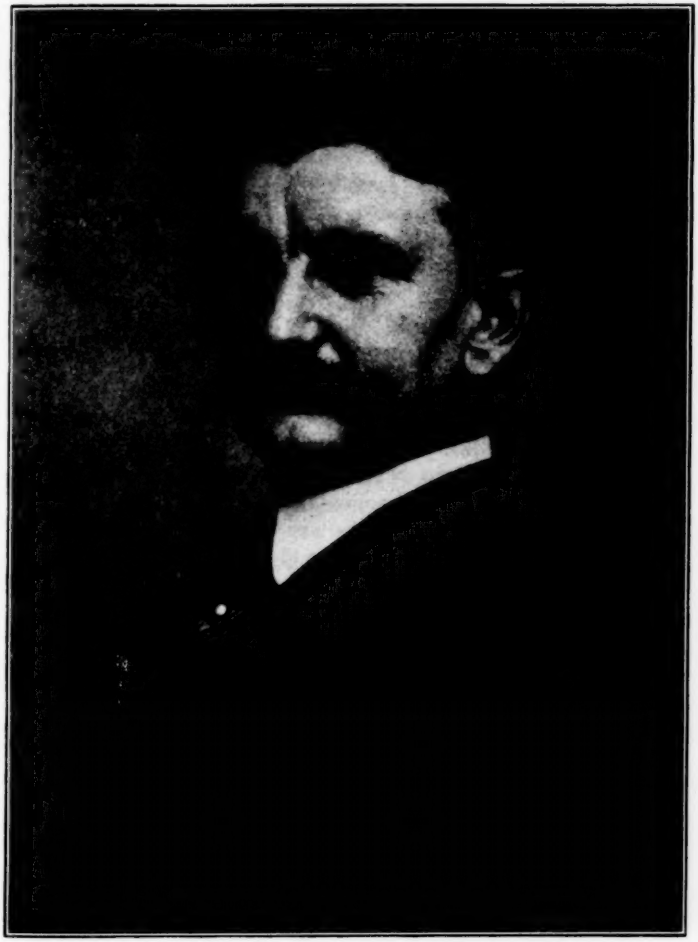
Of those who die nothing but good should be spoken. Dr. Carter was one of the few of whom nothing but good could be said when he was alive. He was never the object of ill-natured jealousy or envy, and many of his intimates who now mourn for him would involuntarily repeat Halleck's famous lines:

> Green be the turf above thee,
> Friend of my better days,
> None knew thee but to love thee,
> Nor named thee but to praise.

His like is rarely seen and to him all unite in giving homage.

> His life was gentle; and the elements
> So mixed in him that Nature might stand up
> And say to all the World, "This was a Man."

ELLSWORTH ELIOT, JR.



DR. WILLIAM GILMAN THOMPSON

Dr. William Gilman Thompson was born in New York City on Christmas Day, 1856, and died in New York City on October 27, 1927. He was educated at the Hopkins Grammar School in New Haven and in Carlsruhe, Germany. He was graduated from the Sheffield Scientific School at Yale in 1877.

After obtaining his degree at the College of Physicians and Surgeons in 1881, he worked in various laboratories and dispensaries in connection with New York University and Bellevue Medical School, where he became Professor of Physiology in 1887 and in Materia Medica and Therapeutics in 1895 and Professor of Medicine in 1897. He was also Professor of Physiology at the Woman's Medical College from 1887 to 1895.

Upon the opening of the Cornell University Medical College Dr. Thompson retired from New York University and became Professor of Medicine at Cornell in 1898, which position he held until November, 1916.

He was visiting physician to the New York Hospital and the Presbyterian Hospital in 1887 at the age of thirty-one—one of the youngest physicians who had ever been appointed as visiting physician to these institutions. He was appointed visiting physician at Bellevue in 1896.

In 1883 Dr. Thompson began to contribute regularly to medical literature and published no less than one hundred and twenty-two articles. These articles were largely on clinical subjects, but there were a number which showed his early interest in matters relating to the progress of medicine but not definitely connected with the practice of medicine. A notable instance is his study of training schools with notes on twenty-two different schools, published in 1883. He also published a text-book on the practice of medicine which served a most useful and valuable purpose in aiding medical students to appreciate the whole range of medicine encompassed in one volume. He also published a text-book on occupational diseases which at the time was the only satisfactory text-book on the subject; also a treatise on "Practical Dietetics," N. Y., Appleton, which was issued in four editions—the first in 1895, and fourth in 1909. His contributions to literature covered a wide range of clinical subjects. He devoted a considerable amount of thought to the construction, management and educational value of hospitals and wrote vigorously about and also on the subject of nurses and nurses' training schools.

Dr. Thompson soon became associated with the New York Academy of Medicine, having been elected a Fellow in 1885. He showed a continued interest in its welfare and activities. He served as Vice-President 1904 to 1906, and as Trustee from 1909

through 1924. He was also elected a member of the Library Committee in 1894.

In his association with the Academy, Dr. Thompson was most assiduous in his duties. He attended meetings and took part in discussions with a definite sense of responsibility and was always clear and forceful in his remarks, showing always sound judgment and clear thinking.

Dr. Thompson rendered his greatest service to the Academy during his period of Trusteeship. He was always keenly alive to the responsibilities of this position. On more than one occasion he was offered the nomination as President of the Academy, but declined on the ground that he already had too much to do.

As he approached his seventieth birthday he was firm in carrying out his resolve to retire from all committee work and resigned from all Academy committees.

Dr. Thompson was a man of great kindliness of character, with a deep human interest and sympathy, positive and at times dogmatic in his statements but always willing to compromise upon hearing the arguments of others, showing a rare open-mindedness.

As a teacher he had the opportunity of influencing hundreds of young physicians and was always a willing and helpful advisor to his former pupils.

Notwithstanding his years, he had the mental and physical vigor of youth, and it was often a surprise to his friends when they realized that he had passed three-score years, for his appearance, manner and mental outlook were those of a man twenty years younger.

His presence and his activity will be sorely missed, not only in medical circles, but also in civic institutions, to which he contributed a large amount of his time and energy.

DEATH OF FELLOW

FREDERIC SILVESTER MASON, M.D., 16 Fifth Avenue, New York City; graduated in medicine from the Medico-Chirurgical College, Philadelphia, Pennsylvania; elected a Fellow of the Academy, January 4, 1918; died, October 29, 1927. Dr. Mason was a Fellow of the American Medical Association and Assistant Syphilologist at the Bellevue Clinic.

1927

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